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STATUS OF THE DEPARTMENT OF MEDICINE AND SURGERY OPERATING FUNDS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

SEPTEMBER 7, 1988

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STATUS OF THE DEPARTMENT OF MEDICINE AND SURGERY OPERATING FUNDS

WEDNESDAY, SEPTEMBER 7, 1988

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:30 p.m., in room 334, Cannon House Office Building, Hon. G. V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Gray, Harris, Stenholm, Rowland of Georgia, Penny, Solomon (ex officio), McEwen, Bilirakis, Ridge, Hammerschmidt, Smith of New Jersey, Rowland of Connecticut, Kennedy, Evans (ex officio), AuCoin, Hefner, and Ray.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. MONTGOMERY. The subcommittee will now come to order.

The purpose of our meeting is to receive testimony about the financial situation in the VA medical centers. However, we are also talking today about the future of the VA medical care system.

It is clear that the VA cannot continue operating in the way it has been over the past few years doing more work with less funds.

For a while the VA was able to take advantage of shorter lengths of stay to care for more veterans as in-patients. For a while the VA has also been able to treat more veterans as out-patients. But those times are over. We have used up the slack.

Now veterans get clinic appointments for dates that are many months away, so the veteran gives up on the VA medical service and they go to private hospitals. This worries me. We cannot let this attitude of "Go somewhere else" overtake our duty and responsibility to provide medical care for the Nation's veterans.

I strongly believe that our committee will continue to act in a bipartisan and cooperative way on this problem.

I wish to emphasize to everyone here that we are not seeking to place the blame for this problem on this administration, as we think the process of restraining the medical care budget has really been going on during two or more administrations.

OMB middle managers appear to be the problem. Let me repeat that. OMB middle managers—Office of Management and Budget middle managers—appear to be the problem.

Someone once said that a picture is worth a thousand words, so I'd like to direct your attention to the chart on my right. It tells the story very well of current dollars in the medical care account,

which starts at $4.4 billion in 1977 and goes up to $10.5 billion for this fiscal year.

The significant part of this graph is the line which is marked "1977 dollars." It is the VA appropriation in constant dollars with the inflation factor pulled out. What it says is that the medical care budget has not grown. Just look at that line. It is just straight across. That means we are trying to handle the increased medical care work load with the same amount of real dollars that we had in 1977.

Let there be no mistake, however, that Congress continues to affirm its desire for a vigorous medical care system for veterans. In Public Laws 99-272 and 100-322 the Congress has set clear eligibility for the ranges of services provided by the VA, and the Congress continues to provide a bigger budget than the VA and OMB requests. Congress always authorizes and appropriates more funding than is requested by the VA and the OMB.

When we heard about the problems being faced in the field we sent out four of our staff members to investigate. They found that special salaries to recruit medical staff were funded by money that was intended for medical equipment and building maintenance. I think in this report if you just look at the different hospitals you will see where they transferred money, the number of beds closed, and what they did with the different funding that they had to work on. It is documented very, very well in this report.

They found that money shortages and staff shortages resulted in closing beds. They found hospital beds closed that were reported by the VA as operating. In other words, we document everything I'm saying right here in this report.

In order to make sure that the results were not limited to just a few hospitals we sent out a written survey to all the medical centers. The survey found that 22,000 medical staff would be required to bring the VA up to comparable private levels. There are about 7,000 unfilled medical jobs in VA hospitals.

Attempts to recruit and retain personnel have been made by taking over $105 million from equipment and maintenance accounts. They did this in fiscal year 1988 alone.

VA hospitals face, in fiscal year 1988, operating expenses of nearly $250 million more than the funds provided by the VA Central Office.

The survey also found that OMB has, for 4 years, required—and listen to this—a 1 percent a year reduction in staffing through improved productivity. Really this is impossible to do when you already have staff shortages.

We have invited the administrator and members of his senior staff to be with us today to talk about the problem. In addition, we have invited VA employees from around the country to tell us about their facilities.

The willingness of these field witnesses to come here shows what kind of employees the Veterans' Administration has. I have visited many hospitals around the country and I have met with a number of these people, and they have stayed with the VA even though salaries are lower and work loads on the ward are harder and higher. And they are here today because they care about the VA medical system.

I want to make a couple of statements about the agenda. Sitting with us are Lane Evans, who is the Chairman of the Subcommittee on Oversight and Investigations. We are very glad to have you here, Lane. And we also have with us Congressman Les AuCoin, who is from Oregon and serves on the Appropriations Committee. He called and wanted to be a guest. I asked him to testify, and he said he would rather sit with the committee. You certainly will be given time to make any requests or any remarks you'd like to make, Les. Thank you for showing this interest.

We also have three members that are at the witness table: Nancy Johnson of Connecticut, Jim Olin of Virginia, and Ron Wyden of Oregon. They will be our first witnesses. After they have testified, then we will have the different directors and chiefs of staff of the nurses that run these hospitals. After we have heard from them we would like to have the Administrator, General Turnage, and the VA senior administrative staff, along with the a separate panel consisting of Dr. Don Custis, Dr. Paul Schafer, and Ms. Gloria Hope of the American Nurses Association. We will also have the representatives of the different veterans organizations.

Now I would like to turn over for any comments you'd like to make John Paul Hammerschmidt, the ranking minority member of this subcommittee. John Paul?

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman. I'll simply begin by commending Chairman Montgomery for his tireless efforts to bring to light the seriousness of the existing Veterans' Administration resource crisis. And let's make no mistake: a serious resource shortfall does exist.

I believe there are several factors which have contributed to the problem. I believe the summit agreement between the President and the Congress may have imposed unrealistic fiscal constraints on the Veterans' Administration health care system. The unrealistic productivity improvements imposed by the Office of Management and Budget have compounded the problem. And, of course, the shortage of health care personnel is a contributing factor.

The committee survey notes that the staffing problems have been exacerbated by the nationwide shortage of nurses which is having a major impact on health care in both the public and private sector.

In fact, a recent study conducted by the Department of the Army on this matter affirms that its nursing shortages are identical to those of the Veterans' Administration. This study concludes that a decrease in the number of students enrolling in and graduating from nursing schools, coupled with the closure of major nursing colleges, poses a significant challenge to the Army's ability to recruit and retain these employees.

The study also notes that the projected nation-wide nursing shortage will be 400,000 by the year 1990. I don't believe we should waste too much time in determining what went wrong or who is to blame, but rather we should move forward in a bipartisan effort to determine what must be done by both the administration and Con-

gress to maintain VA medicine as a viable health care delivery system.

Mr. Chairman, I still believe the Veterans' Administration hospital and medical research system is one of the finest in the world. Thanks to you, Mr. Chairman, and to Gerry Solomon, the ranking member of this committee, our country's veterans will soon have a cabinet secretary with the needed clout to assure that America's veterans continue to receive the health care they have been promised.

I regret, Mr. Chairman, that I have scheduled a markup over in the Public Works and Transportation Committee at 2 p.m., so I won't be able to hear all of our witnesses. It doesn't take anything away from my interest in this matter.

Thank you very much for the time.

Mr. MONTGOMERY. Thank you, John Paul. I have certainly enjoyed working with you on this subcommittee. Thank you very much for this statement.

I totally agree with you. We know we have got the best system in the world, and we want to keep it like that as far as taking care of the veterans and their medical needs.

Gerry Solomon is the ranking minority member of the full committee. We are very glad to hear from you.

OPENING STATEMENT OF HON. GERALD B.H. SOLOMON, RANKING MINORITY MEMBER OF THE FULL COMMITTEE ON VETERANS' AFFAIRS (EX OFFICIO)

Mr. SOLOMON. Thank you very much, Mr. Chairman.

Mr. Chairman, this is an important hearing, and a hearing being held out of a bi-partisan concern for adequate veterans' health care, and I am attending as the ranking member on the full committee in my capacity as an ex officio member of this subcommittee.

My statement is going to be short and to the point and no one will mistake what is on my mind when I'm finished, I'm sure.

Clearly and indisputably the VA medical care system for veterans is in a very, very tight funding situation for the remainder of this fiscal year and for next year. While some say that the VA will not violate the Anti-Deficiency Act, some VA hospitals are having to strip their equipment and maintenance and repair accounts in order to cover daily operating costs. Some VA hospitals are delaying elective surgeries until after October 1st when fiscal year 1989 funds become available, and some outpatient clinics are stringing out appointments to save money. Whatever the reasons may be, this is no way to run hospitals.

The VA must have known for several months that there was not enough money to finish out this fiscal year which ends on October 1st. They must have known that there wasn't enough money to finish it out in a normal operating procedure. Consequently, I am most distressed that the committee had to find out on its own about the situation and that a hearing was even necessary at all.

Obviously the VA had to operate within the constraints of the budget summit agreement between the President and the Congress—and gentlemen, that's you and me and every member of this

Congress. If the budget summit agreement did not give the VA enough funding to do its full job, a job of providing health care for veterans, this committee should have been given timely notice.

Mr. Chairman, the VA must have adequate funding for veterans' health care. I absolutely insist on it, and I know you and John Paul Hammerschmidt and every member of this committee does also. Together with all of the members of the committee and with the American veterans we should take our case to this and the next administration and to our colleagues on the floor of Congress.

Mr. Chairman, let me just say that we talked about their being serious funding as far as this committee is concerned, and I personally believe that the Veterans' Administration sitting out there is mainly responsible, but I also think that this Congress is co-equally responsible. I'm looking at a bill right here which was signed into law. I look at the three members sitting down here that are ready to testify. I look at Mr. AuCoin here. Every member of this committee right here today voted yes on this bill, P.L. 100-322.

This bill, in itself, creates an expenditure for the last 3 months of 1988—the 3 months that we are in now—of somewhere of about $70 or $80 million. The bill, itself, creates an expenditure imbalance of probably somewhere in the neighborhood of $160 or $170 million for 1989.

So if we are going to deal with this thing I don't think that we ought to be sitting here pointing fingers at each other, and I'm not blaming you and me, I'm not blaming the Veterans' Administration, but I'm saying that we had better get together and get on the ball and straighten out this serious problem that exists here today.

I believe that there is a shortfall, counting the end of 1988 and next year, of in the neighborhood of $700 million to $800 million. That's a lot of money. Where are we going to get it when we are bound by this budget summit restraints? Think about it, because we have got to do something about it.

So, Mr. Chairman, I really do appreciate your cooperation in this matter and take my hat off to you for holding the hearing today.

Mr. MONTGOMERY. Thank you very much for your strong statement Gerry Solomon.

Would anyone else like to make a comment? Roy?

OPENING STATEMENT OF HON. J. ROY ROWLAND

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman.

I just want to reinforce what you have said about our purpose here today. We want to find out about the financial situation in the VA and how it affects the quality of care delivered in the VA's medical care system.

We certainly don't want to try to ascribe any blame in particular, but we want to look at this overall in a good, bipartisan manner.

As you know, I have been particular interested over the years about ensuring that high-quality medical staff be recruited and retained in the Veterans' Administration system.

We know that the VA, like many Federal agencies, is having difficulty keeping up with salaries in the private sector. And, in addition, the findings in our survey of medical centers about the differ-

ence between authorized VA staff levels and staff levels in the private sector are really very troublesome. These findings are especially serious when we look at the reported vacancies in the authorized personnel ceilings.

Recently I read a transcript of a conference call that was held among VA hospital directors which put into very practical terms, I think, what is happening out in the field. This is a quote from that transcript, "We have had all the flexibility taken from us in the forms of types of ceilings, floors. Probably the most damaging is this artificially high employment ceiling that we have had to keep over the last couple of years. They are artificially high because the dollars that were originally appropriated to support them have really been drastically reduced or eroded through increases in health insurance and productivity reduction, non-service-connected work load reduction, and so on and so on.

"Those of us in the field I think have cooperated in trying to achieve the goals that you have set for us the best we can, and we have done this in all sorts of ways that we have been taught not to do, and that is that mainly we have been using non-recurring dollars to support recurring funds."

Let me give you another quote from a director, "When do we start closing down the hospitals, and in what increments? Because we just cannot continue to go on the way we are. Our hospital has frozen every dollar of equipment money, every dollar of non-recurring M&R, and you know we have frozen employment and we are now saying, 'Where do we go from here to keep the place open?'"

Mr. Chairman, I know in my own district there is talk of closing the surgical service at the Dublin VA Medical Center. You can't make serious decisions like that without really understanding the problems faced by the VA, and without really understanding what the options might be.

Mr. Chairman, that's the reason that I believe we are here today. Thank you.

Mr. MONTGOMERY. Thank you, Dr. Rowland. Being the only active practicing medical physician in the Congress of the United States, we are very honored that you are on our subcommittee, and you have certainly helped. I know you will help today to find out who is right in this situation.

If there are no other comments the chair would like to move to our colleagues and Members of Congress. Actually I guess this wouldn't apply to you, but we're going to ask the other witnesses to limit their remarks to 5 minutes so committee members will have time to ask questions, and the Chair.

Mr. KENNEDY. Mr. Chairman, I have a statement I would like to make.

Mr. MONTGOMERY. All right. Let me finish my opening statement and I'll come right back to you.

And then we will go by committee rules in the way of rank in the committee and the way you came in. The Chair will go by the five minute rule for the individual members and give every member on the subcommittee a chance.

The Chair would be glad to recognize anybody else who would like to have an opening statement.

The Chair recognizes Joe Kennedy, a member of the subcommittee.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY, II

Mr. KENNEDY. Mr. Chairman, I want to thank you for holding these important hearings this afternoon, and I also want to commend the House Veterans' Affairs Committee for conducting the two investigations that lead to this hearing.

Mr. Chairman, I'm deeply troubled about the findings of the House Veterans' Committee's investigation. Our government's promise to take care of the men and women who have risked their lives to serve our country is now being threatened by a health care system which lacks the resources to hire an adequate number of health care personnel, to repair and replace vitally-needed health care equipment, and to maintain operating facilities in peak condition. No member of this committee is going to sit back and let this happen.

We have over 13,000 hospital beds temporarily closed, yet we have reports from VA medical directors that veterans must wait several months to receive essential medical and surgical care. We have an out-patient clinic in Boston that has dentists bringing in garbage backs to shield their patients from leaking ceilings, elevators falling nine flights injuring staff, an elderly man breaking his neck after a fall on the stairs because he was too scared to take the elevator. Yet, repair and equipment accounts have been exhausted in order to pay for the scarce health care needs of the personnel.

The VA needs over 22,000 full-time equivalent workers to bring the staffing levels of the VA up to comparable levels in the private sector. We have legislation filed that is heading toward the full committee markup next week that will provide relief for the registered nurse shortage, but this is just the tip of the iceberg.

Doctors, therapists, and lab technicians are also desperately needed. The hospital administrators are scraping every last penny to hire the staff to keep their beds open. But when the money runs out they must close their beds.

In Boston and Brockton, Massachusetts, the VA medical centers have closed nearly one half of their beds, primarily due to staffing reasons. The result has been a reduction in health care services for our veterans.

Congress must have this kind of information and feedback from the Veterans' Administration in order that we can deliver the best possible care to our veterans.

The Veterans' Administration's mission is to work on behalf of the veterans of America and not for the current administration.

With the aging veteran population rising and health care inflation going up, the deficiencies in our health care system can no longer continue if we are committed to fulfilling our promise to our nation's veterans.

I am looking forward to the testimony provided by our distinguished panel of witnesses this afternoon, and I hope that we can get to the bottom of the problem so that we can provide the health care that we have all promised our veterans.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Joe.

Let me go back and forth. The gentleman from New Jersey, Mr. Smith.

Mr. SMITH OF NEW JERSEY. Chairman, in the interest of time I would like to put my full statement in the record.

Mr. MONTGOMERY. Without objection, so ordered.

[The statement of Hon. Chris Smith of New Jersey appears on p. 111.]

Mr. SMITH OF NEW JERSEY. I would like to say that I, like Mr. Kennedy and everybody else in this subcommittee and full committee, am looking forward to the testimony of the witnesses, and hopefully we can get to the bottom of this and find some viable solutions to the problem we face.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you.

Lane Evans, member of the full committee?

OPENING STATEMENT OF HON. LANE EVANS, A U.S. REPRESENTATIVE FROM THE STATE OF ILLINOIS

Mr. EVANS. Thank you, Mr. Chairman. I appreciate your indulgence in allowing me to speak and participate as a member of the full committee.

I want to thank both you and the ranking republican, Jerry Solomon, for holding this expeditious hearing.

It seems to me that we do have a problem. We have struggled to provide a current level of services within the Veterans' Administration's medical department, and yet just two examples I could give you indicate that we are slipping away from that goal.

In Iowa the Iowa City Medical Center announced policy changes that would end out-patient medical care at that hospital for 1,000 Category B and Category C veterans. Fortunately these services have been restored, but I'm not sure that they wouldn't be cut back again in the future.

Secondly, I was made aware of a problem in Las Vegas and in Reno with the out-patient clinic in the Reno VA hospital. The hospital there actually has had to resort to private donations in order to meet their needs for critical equipment to provide the needed services to our veterans.

So if we are having financial problems within the Veterans' Administration I think we need to be aware of them on this committee, and that's why we have to work, as Gerry Solomon indicated, with the VA, and that's why I'm very appreciative that at this first day that we are back after the Labor Day break that you have held this hearing so that we can get to the bottom of this.

I look forward to hearing from our colleagues and the others that will be testifying here today.

Mr. MONTGOMERY. I appreciate that statement. And I think by the time we do go through the witness list that we'll have a pretty good feel on this situation and what the medical care is for the veterans out in the field.

Les, the Chair would like to recognize you, the gentleman from Oregon and member of the Appropriations Committee and visiting member.

STATEMENT OF HON. LES AUCOIN, A U.S. REPRESENTATIVE FROM THE STATE OF OREGON

Mr. AuCoin. Mr. Chairman, I want to thank you for allowing me to sit in with your committee today. I admire the work that you do as chairman. I certainly admire the leadership on the Democratic side of this committee as well as the Republican side. This is a bipartisan committee that I think has done excellent work, and your willingness to let this member who is concerned about the problem sit in on this hearing called as timely as it has been called is deeply appreciated, Mr. Chairman.

I would like to have my statement entered in its entirety for the record as well, Mr. Chairman, if there is no objection.

Mr. Montgomery. Without objection.

[The prepared statement of Congressman AuCoin appears on p. 113.]

Mr. AuCoin. I just want to make a couple of observations.

It appears to me, based on my review of the events that have occurred, that despite the hard work of your committee, Mr. Chairman, as well as the hard work of the Appropriations Committee, our commitment to American Veterans is being undermined.

I think this committee is making an attempt today to determine the where and what-for for that undermining.

I, like many of my veterans who I represent, am deeply concerned, if not appalled, by the cuts the VA has announced. I join Mr. Solomon in his expression of dismay for the lack of notice with which these cuts have been made.

I am told in Oregon in the VA hospital out there that there are people being terminated from nursing home care with 2 weeks' notice.

If this budget problem is as great as it has been told to us by the VA that it is, clearly VA knew about it earlier than 2 weeks ago. And so the question of notice is one that bothers me a great deal.

Beyond that, Mr. Chairman, I have had a growing feeling through the years—and it has come to the fore this year—that we do not have within the agency the strong budgetary advocacy. I think their intentions are absolutely sound, but the budgetary advocacy at OMB fighting for funding levels that the veterans of this country need and deserve is not within the agency.

I can't help but notice that in this year's budget request that came to the Congress through OMB there was a request for $10.3 billion. The Appropriations Committee appropriated $215 million over that request. VA went to OMB with a budget request of $10.5-plus billion. The Appropriations Committee basically gave it the aggregate dollars it asked for.

Now we are being told, at this point in the process, that we have the shortfall, and veterans in Portland are being given 2 weeks' notice that they have to get out of nursing home care. Others are being pushed out. I think that something is very, very wrong here, and I think this committee is absolutely right to try to get to the bottom of it.

I can understand OMB pressures. I also understand the budget summit agreement. The budget summit agreement is basically one between aggregate levels on the defense and foreign policy side and

on the domestic side, and for us to think that the budget summit, alone, is what has caused this situation, I think is wrong, particularly when the requests aren't up to snuff in terms of providing needed services to the veterans.

More than that, I'm going to be very interested to hear how soon the VA knew what the impact of these cuts would be and why they didn't notice Congress earlier about these problems.

Mr. Chairman, I would just indicate a couple of other quick things for the committee before you take your witnesses.

In Portland we find that we now have, at this late point, a $2.2 million shortfall in the VA hospital there. Staffing ratios are at one nurse for every ten patients. This isn't quality care any longer. Under these conditions we are not talking about quality care. We have reached the point of the nurse not being able to provide safe care.

Nursing home contracts are really a thing of the past. In July non-service-connected patients have had their contracts terminated, as I have indicated, with a two-week notice. Up to 80 beds in Portland lay empty—it is not unlike the situation in Boston that Mr. Kennedy mentioned—because of shortfalls. That means more vets in waiting rooms and vets sent home early to make bed space.

I think that is a very significant concern; one that is of great alarm to veterans, and I think it is alarming to citizens who are non-veterans who think our veterans, having served this country, deserve the best health care they can possibly get.

So thank you, Mr. Chairman, for the chance to not only express my views, but also to sit in with your committee and participate in the questioning of the important witnesses who are here.

Mr. MONTGOMERY. Thank you for your very timely comments, Les.

Let the record show that Congressman Richard Ray of Georgia was here, also, and had an interest in these hearings.

Any other comments from the subcommittee before we hear our——

Mr. BILIRAKIS. Mr. Chairman?

Mr. MONTGOMERY. The gentleman from Florida, Mike Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, I wasn't going to make any comments, but I endorse most of the remarks I have heard here today—certainly yours and Mr. Solomon's in particular—but it is just important that we remember the comments that have been made that this is a bipartisan committee, and we are famous for it. But it is just critical that we remain that way, and it is also critical that we be open minded and that we not have formulated opinions before the hearing; otherwise, what is the sense of having it?

I do commend you for calling the hearing, and I know that it is going to be conducted in that type of fashion.

Thank you.

Mr. MONTGOMERY. Thank you, Mike.

Now, I totally agree with what you said, and I think our committee has always felt that the bottom line is what is best for the veteran and his or her dependents, and that's what we try to do.

Tom Ridge of Pennsylvania?

OPENING STATEMENT OF HON. THOMAS J. RIDGE

Mr. RIDGE. Thank you, Mr. Chairman.

I, too, will be brief. More money isn't necessarily the answer to a lot of the problems that we identify in this committee or in other committees, but I think that under the circumstances that I know and that I think are going to develop, in order just to maintain the current level of staffing and to bring us up to speed with some of the equipment needs within the system, clearly more money will be needed.

I do, however, want to point out that this hearing is going to focus on some of the things that aren't right within the VA, and it's clear that that is precisely where our focus should be. Let's not forget those 90,000 or 100,000 beds that are being occupied, that are being used to treat hundreds of thousands of veterans throughout the VA system.

I know we want to focus on what's wrong. There are some shortages, and that's clear, and that's important, and that's where we should focus. But let's make sure that we just target our examination of what is wrong but not condemn the entire VA system or the entire health care delivery system because it is not completely wrong. There are many areas where they deserve a pat on the back because of what they have done and what we are going to encourage them to continue to do.

But I would also say this to you, Mr. Chairman: where it is wrong and where we need more money to fix it I, for one, think that it is a continuing cost of defense for us to care for these veterans, and I think that I can join—and all our colleagues will join—in a very bi-partisan way to find that money to fix it.

I thank you for conducting these hearings.

Mr. MONTGOMERY. Thank you, Tom. I agree. That's what we've tried over the years. You're a soldier, but you're still a soldier when you become a veteran, and that's the way it should be.

If there are no other comments—maybe the witnesses should have gotten up here on the committee and we would have gotten to you a little sooner. But the chair would like to recognize, in this order: because she is a member of our committee, and we are very proud of that, Nancy Johnson will be recognized first; and then Ron Wyden, who has been here one term longer; and Jim Olin would be next.

If there are no objections, the Chair recognizes the gentlelady.

STATEMENT OF HON. NANCY JOHNSON, A U.S. REPRESENTATIVE FROM THE STATE OF CONNECTICUT

Ms. JOHNSON. Thank you very much, Mr. Chairman. I am pleased to have this opportunity to testify before you on what I consider to be a very important matter. I will summarize my testimony in light of the agenda you have set for yourselves.

I am a member of the Veterans' Committee on leave to the Budget Committee, and I mention that because Representative Frost of Texas and myself have chaired a hearing in August on Medicare costs and the reimbursement levels under Medicare and what they are doing to our hospitals.

Perhaps the most useful bit of information that came out in the rather extensive hearing was that, indeed, our hospitals have been forced to absorb dramatic new costs in the last year that could not have been anticipated at the time that current Medicare reimbursement rates were set.

Now, there is a lag in that setting mechanism, and I don't want to go into that. But I was astounded, and I think Martin Frost would join me in saying so, that the dramatic cost escalations over a very short period of time have created these same resource and personnel shortages that we're going to address today in the VA system in the community hospitals of America—small, medium, and large.

For example, just the cost of AIDS prevention in the little community hospital in my home town was $1 million in 1 year. That's staggering. My home-town hospital, in order to attract nurses, had to increase salaries 23 percent in 1 year.

So I think we need to see the new pressures that our VA system is under in the context of those problems that are also causing Medicare to be a real drag on the quality of care offered in hospitals throughout the system.

I have talked with the local veterans' hospital in Newington, Connecticut and found, as expected, a serious shortage of registered nurses, particularly nurses with intensive care and post-surgical training. The shortage has been so acute that the hospital has had to close 20 of the hospital's 55 surgical beds—almost 50 percent

To compensate for the loss, the Surgery Department has juggled its surgery schedule, postponing elective surgery and referring some cases to non-VA hospitals.

Nurses are not the only workers, though, in short supply. The shortage of medical technicians, of pharmacists, of clerical workers, is really plaguing the system. And when you don't have that kind of support system in a hospital, then nurses have to spend time on clerical work rather than in patient care.

Ironically, costs also escalated by personnel shortages. Hospitals end up paying time and a half to get nurses to cover shifts for which there are no regular personnel, to get security officers to cover shifts for which there are not regular security personnel, and so on throughout the system.

So staff and resource shortages are without question eroding both access to care for our veterans and, in many instances, the quality of care.

Nationwide, veterans' health care funding is caught in a squeeze between the growing demand of a rapidly-aging veterans population and the 7-percent average annual hikes in health care costs.

But in my area, at least, and in many areas of the country, a third contributing factor is the strong economy we're enjoying and the accompanying labor shortage that confronts employers in the health care sector and in other sectors as well. So it isn't just a matter of not having enough money; it is a matter, too, of some other things that are going on in our economy.

That brings me to the issue of solutions. In the area of personnel shortages, it is significant, I think, to note that at Yale University Hospital in New Haven, a first-year R.N. starts out at $37,000, including differentials. The VA hospital in New Haven, meanwhile,

is starting people out at $34,000 to $35,000. So while there is a differential, it is not a differential that alone accounts for that VA hospital's significant closure of beds and reduction of services.

A very significant part of our problem is the fact that our nursing schools are now training at 60 percent below their capacity. I think one of the things that we need to look at in terms of solutions is much more aggressive recruitment of nurses so we can use not only the full potential of our society to service our community hospitals, but also to expand nursing personnel in our VA hospitals.

Finally, there are two other aspects of this problem that I want to mention.

One solution, of course, is increased funding, and I join with you in being willing to look for those dollars.

Secondly, I was with Dr. Rowland of the VA when we visited his hospital a couple of years ago, and at that time the hospitals begged us to look at this issue of flexibility—of giving administrators more opportunity to govern their own hospitals and use their own money in a way that is most efficient. I think that's a more significant factor than we allowed here in Washington.

Lastly, the committee's survey does indicate a real need to evaluate and plan for the future. I think we need to undertake that as a real project because the needs of our veterans are changing. In my estimation, our institutions are actually not very well adapted to these changing needs, and I think if we begin to address that we can get at some of the current problems.

I want to leave you with the thought that funding is indeed going to be an essential component in the solution, because as we saw through our hearings in the Budget Committee with private sector hospitals, the new costs—the new costs of drugs, the new costs of AIDS, the new costs of personnel—are simply too steep, and were not imaginable even a year and a half ago when we planned this most recent budget. So the budget is something we just have to take by the horns, and I offer you my help and support in doing that.

Thank you for your time and attention.

Mr. MONTGOMERY. Thank you very much, Nancy.

What I'd like to do is have the other two members give their testimony, and then if we have any comments or questions from the subcommittee, if you have time we'll see what questions might come forward.

Ron Wyden of Oregon, the Chair recognizes you.

STATEMENT OF HON. RON WYDEN, A U.S. REPRESENTATIVE FROM THE STATE OF OREGON

Mr. WYDEN. Thank you very much, Mr. Chairman. I would ask, too, that my statement could be entered into the record in its entirety.

Mr. MONTGOMERY. Your prepared statement will be inserted immediately following your oral presentation.

Mr. WYDEN. Mr. Chairman, first of all I want to commend you. You really set the standard, as far as I am concerned, for advocacy for our veterans. I just appreciate the opportunity to come, and I

think that's why, on a bipartisan basis, you are held in such esteem by our colleagues.

Mr. Chairman, health care is the area that I have tried to specialize in during the four terms that I have been in Congress, and in analyzing the veterans' system over the last few months it is just quite clear to me that there has been a significant deterioration in the quality of care that is available to veterans in this country.

I'd like to outline briefly some of the problems that we've seen on Portland, and then talk about reforms that might make sense nation-wide.

I think our colleagues have made the basic point. It is quite clear that the VA system is now being pushed to the breaking point, and it is the veteran who, in effect, is being broken as a result.

Mention was made, for example, about the nurse-patient ratio in the Portland metropolitan area. For the VA the nurse-to-patient ratio is 1 to 10. In private hospitals in the metropolitan Portland area, the ratio is generally about 1 to 4.

The problems with nursing care are so serious at the Portland VA that we were recently told that at the largest community college nursing school, one of the instructors will no longer send her nursing students to the VA because they don't feel that they're getting proper training and proper role modeling.

One recent rotation at the VA hospital witnessed an unsupervised medical student improperly performing a delicate blood circulation test. Improper administration of this test could result in permanent paralysis for an individual. Fortunately, it didn't happen in this case.

The other thing that concerns me, Mr. Chairman, is that I don't think that the VA is sending out the message that the hospitals around the country, in making these cuts, should focus on preserving priority services first. Priority, life-saving services ought to be preserved first. I'd like to give an example of how that is not being done.

Last Friday a constituent contacted my Portland office because he had been discharged from the VA hospital that morning, though he was still suffering from a bowel blockage. Because he is a kidney dialysis patient, this condition is life-threatening and the veteran needed to go back to the hospital.

It seems to me that those kinds of situations are priorities, and as we look to deal with this budget crunch—and Mr. Solomon is right to mention it—we ought to be sure that the priority services are preserved first.

Mr. Chairman, it seems to me that if we don't act quickly a bad situation—the situation with deteriorating health care—is going to get worse.

At a special budget briefing that was held at Portland as a result of questions I asked of the director there, we were told that we could anticipate staff reductions of 120 positions shortly, including 22 full-time equivalent nursing positions. I think that's the kind of thing you're going to see at hospitals from Portland, Oregon, to Portland, Maine, and really lays out the call to action.

Mr. Chairman, the last point that I'd make is that no Member of Congress voted to have, for example, veterans lie in their feces and

urine for hours as we have seen at the Portland hospital. Every Member of this Congress wants to get good quality care for the veterans in their area.

But the Veterans' Administration has got to play straight with the Congress if we're going to make sure that they get the resources, so they can be used in a flexible way to focus on the priorities for veterans.

I'm not convinced the Veterans' Administration has played it straight with the Congress. They have told us again and again that they're getting adequate resources. It's quite clear that they are not getting adequate resources and they're not getting adequate resources to focus on their priorities. I think they're coming around to that recognition.

I thought I'd finish with a letter that I received from a medical director at the VA in Portland because I think it sums up the situation. What the director said in the letter to me is: "This is in response to your inquiry on behalf of a Mr. X,"—I want to leave the person's name out—"who had complained of a very long wait for an appointment in our neurosurgery clinic. I can certainly understand Mr. X's dismay at a four-hour wait, and I'm sorry he had such an uncomfortable experience.

"Our neurosurgery clinic is presently understaffed. On the day of this visit there was one physician available at the clinic and approximately 38 patients to be seen. New patients often take up to an hour for evaluation, and quite often an emergency in our admitting office calls the physician away from the clinic.

"I regret that Mr. X and other patients were asked to wait so long, and wish to offer my apologies."

Mr. Chairman, I think you're hearing that from every Member of Congress. At this point it is time for us to reach out in a bipartisan way and make whatever budget and policy changes are needed so that priority care for the veterans is made available in this country, and I look forward to working with you and your colleagues to make sure that we do it.

[The prepared statement of Congressman Wyden appears on p. 116.]

Mr. MONTGOMERY. Thank you very much for that statement. It will be a part of the record, and that's what we're trying to make today, a record.

Jim Olin of Virginia.

STATEMENT OF HON. JIM OLIN, A U.S. REPRESENTATIVE FROM THE STATE OF VIRGINIA

Mr. OLIN. Thank you, Mr. Chairman and members of the committee. I appreciate the chance to testify before you today. I have submitted a statement I hope will be a part of the record, and I'll just summarize.

Mr. MONTGOMERY. Your prepared statement will be inserted immediately following your oral presentation.

Mr. OLIN. Mr. Chairman, I'm going to be talking to you about the situation at the large VA medical center in Salem, Virginia, which is in my district. That's a VA hospital that serves Southwest Virginia, and for psychiatric patients it covers all of the State of

Virginia and the State of West Virginia. It has done an outstanding job over the years. This hospital is well honored in the VA system.

Earlier this year I attended a ground-breaking of a $66 million addition to the hospital which is going to permit the consolidation of a number of hospital functions, which will raise the quality of medical care and improve the efficiency.

Mr. Chairman, the reason I'm here today is to talk about the situation that has developed over the last 2 years. I spent a fair amount of time at the hospital talking to the employees there and the patients. Over the past 2 years I have been more and more aware of the crunch that has come on based on funding, but particularly on the mandates on personnel levels for clinical activities. This is very shortly going to reduce the level and quality of the health care given to veterans.

As evidence of this I have attached a chart that shows that since 1983 there has been a 15 percent increase in the number of outpatient visits to the hospital and a 7 percent increase in the veteran population in the hospital.

During that time the hospital has been required to take a 6 percent cut in the number of direct clinical employees. I don't have any objection to tightening things up, and the staff has accommodated to this degree of tightening fairly well. They are stressed, but they are getting it done.

They are now just about at the breaking point, the best I can tell. They have been asked to take off 71 more direct clinical employees going into next year as a mandate. That will make another 5 percent reduction in personnel.

The hospital director feels he cannot provide adequate care for his present load on this basis, and he is going to close two 40-bed wards. It will involve 70 psychiatric and long-term medical-care veterans. They're going to have to be turned out. And for that type of care it is going to be very, very difficult to find suitable care in the community for those men.

I have always felt that we've tried to appropriate enough money to maintain current services for veterans. I think that's what we felt we were doing. And, of course, this is certainly violating that principle.

The Salem Hospital is a 700-bed hospital. It's annual budget is about $60 million. I think it is presently short about 100 employees from what it would take to give good medical service. Its budget is about $2 million short of what is needed.

This situation is going to force a 10 percent cut in the number of beds in that hospital just at time when World War II veterans and Korean veterans are beginning to need more care than they needed before.

I, myself, don't think this is meeting our commitment, and should not be necessary.

I am also told by people at the hospital that in this particular case the RAM system of measurement—Resource Allocation Methodology—is highly suspect as being something that is contributing to the problem rather than helping it. This is a DRG system, as you know, tailored for the VA.

People there do not feel that the RAM system really properly takes into account the nature of this hospital, which is more of a campus-type hospital—it was built in 1934, dedicated by FDR—and it is also a regional center for psychiatric care. Other hospitals, after they have taken in a psychiatric patient and given him acute care, send their patients to this hospital, which takes on the job of rehabilitation.

The hospital has really done a good job in terms of taking psychiatric long-term care patients and getting them improved to the point where they can leave the hospital. And they are now in a position where they are very, very worried about this.

This work can't be done without adequate staff, and the alternate, if you don't have adequate staff, is that these veterans will stay there forever, and that's what they're trying to avoid. We are right at that point.

I'm not sure the RAM system is the whole story, but it is the thing that is putting on the pressure, and it is getting unrealistic in terms of the professional people there that are trying to put forth good medical care.

They say to me that the alternative—they can meet the RAM requirements, but they'll have to shut down this rehabilitation work and basically revert to being a nursing home, and we don't want that for our veterans.

Mr. Chairman, I hope that this committee will be successful in coming up with some answers. This is a serious situation. I have told you the situation at one hospital; I'm sure it exists elsewhere. It is something that really needs correcting.

Thank you very much.

[The prepared statement of Congressman Olin appears on p. 120.]

Mr. MONTGOMERY. Thank you.

The Chair will only take several minutes to ask some questions, and then I'll recognize you, Gerry.

Nancy, in your testimony you mentioned about the cost of AIDS. One of the problems we have in dealing with AIDS as far as the Congress is concerned—I know last year $1 billion was authorized and appropriated to fight AIDS, and it didn't include any money in there for the Veterans' Administration. And then we had another $1 billion for this next fiscal year, and, thanks to our appropriations friends, Ed Boland and Bill Natcher, we were able to get about $60 million over into the VA system. But we're doing the research and we have got the patients. That's one of our problems. This money is authorized and appropriated for AIDS, as an example, but we get only a small fraction of the funds.

Ms. JOHNSON. I think it will be interesting to hear what the administrators say on this subject, but I had not seen, until the testimony before the Budget Committee, the heavy costs that AIDS is placing on hospitals.

Hospitals are having to pay for things like a much heavier grade of plastic garbage pail liner and other precautions that are not obvious. It really gets into hundreds of thousands of dollars very rapidly. Prevention measures like these are not optional whether you have one case or 100 cases.

We have had to raise the standards for much of the ordinary equipment that hospitals use, and it costs a lot more money.

So there are factors out there that are pushing costs up over a very short time frame, and if you add that to personnel and other things and you've got a whole different cost situation than we had a year or two ago when our administrators were making their estimates for the current fiscal year's budget.

This really is a non-partisan issue, and we have a crisis.

Mr. MONTGOMERY. We'll try to find out about that.

Ron, I assume that these complaints came to you on the Portland Hospital and that you were getting more complaints than you had in the past during the four terms you have been in Congress.

Mr. WYDEN. Mr. Chairman, I think my office is getting the same response as other Members of Congress, and over the last 8 months in particular we have kept track of complaints, the number and the seriousness of the complaints has risen dramatically, and I think you'll hear it from virtually every other member as well.

Mr. MONTGOMERY. Well, I want to commend the three of you. It makes our job easier on this subcommittee for Members to go out and take a look and visit these veterans' hospitals and then come back and tell us and allow us to get it right from the field. It certainly helps us.

My last question is to you, Jim. I have a letter that was put out from your veterans' hospital. It came in to my area—came to the Congress here. It says in effect that because of shortages at the hospital at Salem, Virginia, that only service-connected veterans will be accepted for evaluation and treatment. Are you familiar with that letter?

Mr. OLIN. It's coming close to that.

Mr. MONTGOMERY. Sir?

Mr. OLIN. It's coming close to that. When they cut out the 70 beds of course they're not going to discharge service-connected veterans until the non-service-connected are gone. But whereas they used to be able to take non-service people in that were old and in very tough financial shape, that facility has been reduced considerably.

Mr. MONTGOMERY. This letter—we'll ask the Administrator if he is familiar with this. This letter was for the specialty clinic at Salem, Virginia.

The problem is that we have a priority of who gets into the veterans' hospitals, and you have the low-income guy that this would eliminate and knock him out of getting this specialty treatment.

Mr. OLIN. To the best of my knowledge they have not discharged service-connected veterans at this point, but they're getting close.

Mr. MONTGOMERY. My point is that the only ones they're going to see are the service-connected veterans, and we are seeing the others being excluded. That's my point.

Mr. OLIN. Good point.

Mr. MONTGOMERY. Are there any other questions?

Mr. SOLOMON. Mr. Chairman, first of all I want to thank the three Members of Congress that came to testify today. We certainly concur in your remarks, along with Mr. AuCoin's. Mr. AuCoin and I don't often see eye-to-eye on foreign policy and national security

issues, but we want to take off our hat to him on the Appropriations Committee for taking care of the veterans' budget.

Nancy, we also want to thank you. You are a standing member of this committee and have been on leave for some time to the Budget Committee. But, in turn, the Chairman and I know the job that you've done on the veterans' end of it on the Budget Committee, and we thank you for that.

One problem that you brought up was the nursing school training. Schools throughout the country are running at an average of 60 percent capacity. That is a real problem not only for the Veterans' Administration, but for the entire medical care delivery system.

In Albany, New York—the State capital of New York, which my district surrounds—we have very large medical care research and delivery systems, both in the private and in the governmental sector. With the Albany Veterans' Hospital we are short about 71 nurses today. We cannot get nurses. Our problem is bad. The private sector is bad.

Somewhere along the line we have got to do something about that to attract people in. You and Sonny Montgomery had a dialogue on the AIDS situation and the problem that that causes. I think therein lies part of the problem where we have nurses and medical professional people who just are not going into the medical profession because of the fear of the unknown of the AIDS situation.

Not only do we have to fund that properly within our Veterans' Administration hospital delivery systems, which is the greatest in the world and perhaps the best able to take care of both research and medical care delivery systems, but we also have to do something about the nurses.

Sonny Montgomery and I were discussing earlier this morning that the military has a program. Sonny, I guess you are more familiar with it than I am. It's almost like an ROTC program where they attract people into the military medical delivery system through an ROTC-type program. I think maybe it's about time we looked at that in the Veterans' Administration about furnishing nurses and doctors—a program that will allow them to go to school and then be obligated to serve the Veterans' Administration and the government in an area.

Perhaps we can explore that, because this situation—I've watched it happen now for 8 years. It just gets progressively worse. Part of it is because of funding; the other part is because of people just not wanting to go into that profession.

Ms. JOHNSON. If I may just comment: I really commend you both on undertaking these hearings because I, unlike my colleagues, am not getting any calls to my office about people who are being denied service. I'm not here because of that kind of outcry. But I am here because of the erosion of quality that is beginning and that is going to escalate rapidly and really affect our veterans very, very deeply.

If you look at what has happened with Medicaid where we have failed to increase reimbursements commensurate with the growth in costs, you know that that has caused low-income families in America to have less access and lesser quality care.

I'm afraid that if we can't respond in a concrete budget fashion to address what what we see happening in our VA hospitals, then our veterans will see this same seepage of both access and quality.

So I think those long-term thoughts are just every bit as important as the short-term funding issues.

Mr. SOLOMON. Well, again I thank all three of you for your testimony. I really appreciate it.

Mr. MONTGOMERY. Thank you very much.

Dr. Rowland? We'll hear from Dr. Rowland, and then the next panel will be coming up.

Dr. ROWLAND OF GEORGIA. Quickly, let me just thank all of you for being here and for the comments that you made.

Nancy, you drew a parallel between the problems in Medicare and the Veterans' Administration. As you well know, Ways and Means had to find about $24 billion for the two-year budget summit; $5 billion of that came out of Medicare to try to meet the deficit reduction target.

There is a difference between that situation and the VA because about 70 to 75 percent of the care in this country is provided by the private sector. About 25 to 30 percent is in the public sector. So those hospitals that are having trouble because of costs in Medicare can shift over to the private sector. They can maintain their quality of care by doing that, and that is exactly what they're going. The VA doesn't have that. The VA doesn't have a private sector to shift to, so they are caught in a situation which they can't deal with, and they are getting money from other accounts in order to try to meet that.

You mentioned going to Dublin and the fact that they are crying there about the ability to shift funds to medical care from other areas. If funds are earmarked in the VA you can't shift it to another account. For example, if there is money that is earmarked for a renovation, you can't shift that to medical care.

Now, I would like to see the local directors have the ability to do that, but they can't. For some reason, although we have tried in this committee to do that, in the past we have met opposition, as I understand it, from the Appropriations Committee, we have met opposition in the Senate not wanting to give the flexibility to the local hospital directors. So I just want to call attention to that as being something that could be done in order to provide more funds for medical care.

Let me mention, Jim, about the RAM DRG payment system. It doesn't work. It doesn't work in the private sector. It is killing the rural hospitals, and it is doing the same thing in the Veterans' Administration. It seems that we will never learn by things that have happened in the past what we might expect in the future.

Again, I thank all of you for being here.

Mr. MONTGOMERY. Thank you.

Thank you very much for being here. I appreciate it.

We would now like the second panel to please come forward. I know some of you have been wondering about Congressman Bill Hefner sitting up here and which committee he was on. We're very glad to have Bill. He's going to introduce the director of the Salisbury Hospital from North Carolina, and then I will introduce the other panel members.

Thank you, Bill Hefner, for being a great friend of the veteran, and I have been to your district several times visiting that hospital.

STATEMENT OF W.G. (BILL) HEFNER, A U.S. REPRESENTATIVE FROM THE STATE OF NORTH CAROLINA

Mr. HEFNER. Thank you, Mr. Chairman, for extending this courtesy to me. I would just like to thank this full committee on behalf of those of us who do not have the privilege of sitting on this committee—but who do have VA hospitals in our districts—for the fine work that you do that enables us to better serve our veterans.

It is my special privilege, Mr. Chairman, to introduce this gentleman and to submit for the record some of his qualifications.

Mr. MONTGOMERY. Without objection, so ordered.

Mr. HEFNER. Mr. Thomas L. Ayres, who is a very dear friend of mine, is the director and chief executive officer of the Veterans' Administration Medical Center in my congressional district in Salisbury, North Carolina.

We are very proud of this hospital and the good work that Tom and his able staff have done since he has been there. He has been at the Salisbury Hospital since September of 1981.

Since 1959, Tom has served the Veterans' Administration in various capacities at six medical centers throughout the United States.

Prior to coming to Salisbury he served at the VA Central Office here in Washington as Executive Assistant to the Associate Chief Medical Director.

Tom served in our armed forces as a medical corpsman in the U.S. Army from 1956 to 1959.

In addition to his duties as director of the 904-bed Salisbury facility, he is responsible for the VA out-patient clinic located in Winston-Salem, which operates the VA out-patient program for the State of North Carolina. This responsibility includes services to 5,600 in-patients and 78,000 out-patients annually.

And for his work on behalf of veterans he has received numerous service awards from veterans groups, including the DAV and the VFW.

He is a committed and capable man, and at this particular time I would like to submit the following information, Mr. Chairman.

Mr. MONTGOMERY. Without objection.

[The information appears on p. 126.]

Mr. HEFNER. So it is with great pleasure that I introduce my friend and the director of the VA hospital in Salisbury, North Carolina, Mr. Tom Ayres.

Mr. MONTGOMERY. Mr. Ayres, hold up your hand. Thank you.

Mr. AYRES. Thank you.

Mr. MONTGOMERY. I hope that introduction wasn't so good that some private sector will come and take him away from us.

Mr. HEFNER. Mr. Chairman, he has an unlisted number, so they can't.

Mr. MONTGOMERY. Well, thank you, Bill Hefner. We want to thank you for your interest in coming here today and introducing Tom Ayres, who is the Director of the VA Medical Center.

Mr. John Fears is the director of the VA Medical Center in Hines, Illinois. Hold up your hand, sir. Thank you for being here.

Smith Jenkins is the director of the VA Medical Center at Boston.

And Dr. Musser, a friend of ours, is the Chief of Staff at the VA Medical Center in Atlanta, Georgia.

The Chair would like to recognize Mr. Solomon before calling on our witnesses.

Mr. SOLOMON. Mr. Chairman, I do thank you, and I want to thank these gentlemen for coming here from their respective hospitals.

I just want you to know that Chairman Montgomery and I met with Tom Turnage on a number of occasions, but most recently I think about a month ago when we talked about holding these hearings.

I just want you to know that Tom Turnage told Sonny Montgomery and me that he expected everybody to come in here and be forthright, and naturally to tell the truth—we know you would do that. But he said he just wanted everybody to know that no matter what there would be no reprisals or anything like that, and I think he was saying that most sincerely. And if there is anything like that, he wants to know about it and I want to know about it and so does Sonny Montgomery.

So we really do appreciate your coming in here to testify today.

Mr. MONTGOMERY. I think that is very important and I'm glad you put that for the record.

I like to go by seniority. Who is ranking?

Mr. AYRES. I believe that would be Dr. Musser.

Mr. MONTGOMERY. Dr. Musser, go ahead, sir.

STATEMENT OF WENDELL MUSSER, M.D., CHIEF OF STAFF, VETERANS' ADMINISTRATION MEDICAL CENTER, ATLANTA, GEORGIA

Dr. MUSSER. Thank you very much.

First of all, I have spent the majority of my professional career in the Veterans' Administration. I look upon it not as a place of employment, but I really look upon it as a place of fulfillment of my professional need.

I have had the opportunity in my career to have been taught by some of the great men that have made this organization what it is, and they have taught me to show respect, especially for the office of Administrator and the office of the Chief Medical Director, and I do that with only humility.

These are difficult times. We have reached a crisis level. We have found out the hard way that we are running out of money in fiscal year 1988.

I will try to tell you the truth as I see it through my feeble intellectual ability. I will try not to tell you things I don't know.

It is time not to just look at budgets, alone. It is time to consider the concept, tradition, mission, and the future of the Department of Medicine and Surgery as it takes its rightful place and role in the evolving health care system of this country, not just the Veterans' Administration.

I'm going to make this brief, but I would like to read something to you which has meant a great deal to me over the years.

On May 2, 1947, Gen. Omar Bradley sent a letter to all assistant administrators and deputy administrators, and that letter stated, "Next week I shall go before the Congress to show why we shall need $7 billion for the VA in 1948. However justified our requirements may be, these vast expenditures offer a challenge to reduction in government spending. Even the accepted necessity of our veteran programs cannot save the VA from becoming a target in this effort to reduce the budgets.

"The VA has sought reductions wherever reductions might be made without impairing our operations, but if further reductions in the name of economy threaten to cripple our program and dull its objectives, I feel it is my duty to point out the danger.

"Where reductions and expenditures for hospital treatment might threaten the standards of medical care I shall oppose such reductions and defend the budget we shall need."

Deja vu.

The hospital I know the best, of course, is Atlanta. Atlanta was one of the 16 hospitals surveyed by the staff of this august committee. That is a matter of record. It shows that not only did we utilize precious M&R money and equipment money to buy drugs, blood, and hire people in order to survive fiscal year 1988; it shows that the shortfalls will roll over into fiscal year 1989, and that in this one institution alone it will probably amount to a $5 million shortfall.

I can go through the data that we submitted to you item-by-item if you so desire, but I think it is a matter of the record.

Let me say that in all due respect—and I hope no one takes offense at this—the Congress cannot possibly appropriate, under the present economic pressures of this nation, the money necessary to address the shortfall to reach current service levels. I think the most conservative estimate in my mind—and I have served with the guidance and pleasure of the Chief Medical Director on several groups—that we are $1.46 billion short. I cannot see, in my humble estimation, as to how the Congress can address this in the face of legislation that it must respond to relative to the deficit and other economic factors of reality that we face.

I think each and every one of us has to recognize the reality that we will do the best at the highest quality, that we will utilize the dollars as efficiently as we can, we will control the work load, and, I'm sorry, in essence we will ration health care because we will have no other choice.

I heard Dr. Rowland from my home State of Georgia speak of flexibility. We need to address that sort of flexibility to get more out of the dollars we have available. We need the freedom to manage.

We ask you to consider, in whatever methods available to you, relief of those floors and ceilings and corridors and restrictions to our opportunity to manage the dollars we will have to give the maximum quality health care available to the veterans.

I am not capable to speak to the necessity of addressing redistribution of resources; that's beyond my capabilities and data. I can address the fact that there is a great disparity in access to veterans to care across this country. In some way or another in some mechanism we must address access parity.

I cannot address in detail, but we should look at the mission of each of our individual hospitals as we try to get the most out of the dollars available.

Mr. MONTGOMERY. Dr. Musser, I believe your time is up.

Dr. MUSSER. And I am finished, Mr. Montgomery.

Mr. MONTGOMERY. Thank you. Who wants to be next?

Mr. FEARS. I guess that I am the next senior.

Mr. MONTGOMERY. Go ahead.

Mr. FEARS. I have 13 years.

Mr. MONTGOMERY. Okay. And you don't have to make a full statement. We'd like to get into the questions if we could.

STATEMENT OF JOHN FEARS, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, HINES, ILLINOIS

Mr. FEARS. Mr. Chairman, most of the points that I would have made today if I spoke a long time before this group have already been made by previous witnesses and members of the committee. I think you really understand quite well what the situation is, and I really wouldn't have a whole lot to add to that.

I was particularly interested in the remarks of Mr. Solomon and Representative Johnson. I think those hit very close to home as far as Hines Hospital in Chicago is concerned.

I think we really have three issues here that we need to look at. The first is operating funds. When I talk about operating funds I am talking about recurring dollars to actually deliver health care.

We're talking about operating beds which have not been closed for efficiency of operation. I think these beds are an issue that we need to look at.

And the third thing I think we need to look at that is very important is the nursing shortage. It really is a problem.

In operating funds our recurring base has been reduced year after year through productivity cuts and different types of other fund reductions that have already been referred to by previous witnesses..

The only thing that I don't think has really been emphasized here is the fact that the cost of medical care is going up. I know Representative Johnson did give some cost. At Hines the cost of protecting our employees from the AIDS virus will exceed $1.2 million a year in additional cost, and I have to absorb that sort of a cost, while at the same time we are giving additional programs to our veterans, such as the homeless program, and we don't get any dollars for those particular programs.

The other thing that is becoming more costly is the cost of technology. I will give you a couple of examples of that. Hines was fortunate enough to get an MRI, to get a mammography unit, and to get some filmless radiography equipment. We are very thankful for that; however, the contractual cost of maintaining that equipment will exceed $450,000 a year from here on out, and I am expected to absorb that particular cost.

We have a heart transplant program at Hines. We are very proud of it. It is cutting-edge technology.

The cost of maintaining those patients exceeds $20,000 per year. The minimum cost is $20,000 per year. Now, we have done approxi-

mately 20 heart transplants and we have another 10 on our rolls that were done elsewhere, so there are 30 patients that we have to maintain on medications that are very expensive. We have to do biopsies, which are very expensive. So the cost of health care is going up. In the meantime, as you pointed out, the recurring dollars stay the same.

I am proud to say that, in spite of some of the statements that have been made today, I don't believe one veteran in the Chicago area has been denied health care because of any budgetary constraints. However, I do think we're like a rubber band that has been stretched to its limit, and if we pull it any tighter it is going to break.

I think that you gentlemen of Congress have a real job, because there are some issues out there that really need to be looked at, and we need you to get more funding or we need to reduce work load. We need to do something if we are going to maintain a viable health care system for our nation's veterans.

Thank you.

Mr. MONTGOMERY. Who's next? Mr. Ayres?

STATEMENT OF THOMAS AYRES, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, SALISBURY, NORTH CAROLINA

Mr. AYRES. Thank you very much. Mr. Chairman, I thank you for the opportunity to appear before you and your committee and share my thoughts with you pertaining to the issues that you suggested as subject matter for General Turnage.

Providing health care and benefits to our nation's veterans is a great responsibility, but a privilege which we gladly embrace. One only needs to visit a VA medical center and talk to our patients to realize the tremendous personal sacrifice and hardships they have endured to ensure freedom for all of us.

To continue meeting their needs we must squarely face the issues and seek appropriate resolutions.

I, along with brother Wendell, have had the privilege of sitting at the feet of some very learned VA directors—Dr. William S. Middleton, Dr. Arthur Klippen, Dr. William Merchant, and Dr. Don Custis.

I'd like to give you a brief scenario on what the 1989 budget shortfall would mean to VAMC Salisbury.

As far as our medical center is concerned—and to put it in a little North Carolinian humor—fiscal year 1988 is graveyard dead. We will close our books at the end of this month, and hopefully—and I'm sure—be solvent.

The Veterans' Administration Center's Salisbury budget shortfall for 1989 is estimated at $2.8 million. We will have to reduce our work load if this is realized.

Two ways this could be accomplished—and I will list them in order of unpleasant preference—are as follows: option one, reduce in-patient psychiatric care, reduce average daily census by 92, reduce full-time equivalent employees by 84; option two, reduce in-patient intermediate care beds, reduce average daily census by 102, reduce full-time equivalent employees by 82.

These reductions would entail closing buildings or floors in order to reduce full-time equivalent employees. If authority were given, and the worst scenario comes to pass, we could absorb the shortfall by accomplishing the following: if we provide community nursing home care placements to service-connected veterans only, $1,736,000 and some odd change would be realized; eliminate over-the-counter drugs, $744,000; eliminate beneficiary travel, $159,000.

These reductions, coupled with a discontinuance of out-patient care for category B's and C's, would realize a savings for us to continue to operate in 1989 of $2,749,367.

It is important to note that this medical center's target allowance for fiscal year 1989 has already been reduced by the following externally-imposed penalties prior to the impact of any shortfall adjustments. Similar adjustments have occurred in previous years.

The 1 percent productivity initiative is equivalent to 12.1 FTE, $411,987. The HCP savings is equivalent to 0.9 FTE, $52,667; standardization savings, $16,866; recurring distributions and adjustments, MEDIPP contingency withdraw, 5.1 FTE, $232,338; homeless ill, mental ill withdrawal, 0.7, $49,808; homeless domiciliary program withdrawal, 0.5 FTE, $65,099. Total FTE, 19.3. Total dollar reduction prior to the target allowance, $828,765.

Getting away from the 1989 budget I would like to move on to one more issue. This medical center has the authorized capacity of 904 beds, including a 93-bed nursing home care unit. Over the past several years we have found it necessary to readjust our beds due to specific changes and demands. Specifically, we have created a 20-bed rehabilitation medicine unit by redesignating 20 acute medical beds, converted 12 beds in a psychiatric, readjustment program to acute psychiatry and reassigned 20 psychiatric beds to activate one of the most modern psychiatric intensive care units on the East Coast.

As I see from the light, I am out of time. However, Mr. Chairman, I would like to mention one more fact. A popular sport of late has become the bashing of federal employees. This comes from within our organization, and it comes from without. It also diverts attention from the real problems and sends a negative message to dedicated health care employees.

Thank you for the opportunity to be here with you this afternoon.

Mr. MONTGOMERY. Thank you, Mr. Ayres.

To answer your last comment, the best friends you have as far as health care professionals and VA employees is this committee and the Congress, as a whole. We don't have any problems with our bills. If we get one or two votes against our bills I get terribly upset. So it is not your Congress, it is other areas. So don't let the VA employees think you don't have friends in Congress.

Mr. AYRES. If we had the time to address the issues that have been surfaced by my colleagues and other people this afternoon we would have gotten into some other areas in which we rely on your support—especially in construction and other important issues that we've had from this committee over the years.

Thank you.

Mr. MONTGOMERY. Thank you, Mr. Ayres.

Mr. Jenkins?

STATEMENT OF SMITH JENKINS, JR., DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, BOSTON, MASSACHUSETTS

Mr. JENKINS. Mr. Chairman, I'd like to thank you for the invitation today and offer some remarks concerning the present status of the Boston VA Medical Center.

The major problem that has faced my medical center for the past 18 months has been its inability to attract and retain nurses and LPN's.

Although this medical center has utilized numerous innovative techniques, we have been unable to achieve the staffing levels that we enjoyed 2½ years before.

I'm going to add that the recruitment of nursing personnel in the metropolitan Boston area is highly competitive. Private and public hospitals are constantly striving to attract nursing personnel through salary and benefit enhancement.

Currently, we have authorized 311 R.N.'s. On board and working today we have 257, so we have 54 vacancies.

In LPN's we have 88 authorized, and we only have 36 on board. We have 52 vacancies in LPN's.

The use of special pay rates has played an important role in maintaining some staffing stability, and we will be forced to continue matching community rates.

Our most recent special rates, which were approved in July, were of considerable help. But the entry level pay has reached its maximum amount allowable by law. These are the junior- and associate-level pay salaries.

Our junior grade nurses come in presently at $26,967. That is the equivalent of a 19th step within that grade, and the law will not allow us to exceed that amount presently. We have requested relief from this through our Central Office.

The present prevailing rate in Boston right now for an entry-level nurse brand new out of school is in excess of $30,000. So, as you can see, we are about $3,500 behind right now with our most recent approved rates.

The nursing shortage has resulted in my facility closing 192 beds. There are also another 106 beds closed due to other reasons. That leaves us with 454 available beds for occupancy. This has significantly impacted our work load.

During fiscal year 1986 we treated almost 13,000 veterans as inpatients at the Boston VA. This year, fiscal year 1988, we will treat approximately 8,500. This has resulted in approximately a one-third reduction in our work load. This will eventually show up in revenue losses for my facility in our resource allocation methodology.

We also presently either have approval for or pending 15 different special rates for the Boston VA Medical Center, at a cost of $2.6 million. We have presently been funded for $2.3 million of that cost.

In fiscal year 1989 we anticipate that cost going up to $2,997,000—almost $3 million—of which approximately $600,000 of it will not be funded by Central Office.

I will read a brief paragraph from a site visit that was recently completed in my facility concerning the patient care environment, and I read it because of its budgetary impact.

"The Boston VA Medical Center's physical plant is in desperate need of improvement and modernization. Since the medical center's activation in 1952 there has been only limited improvements in the physical plant. A research building and an MRI unit have been the only major improvements during those 36 years.

"Patient care wards, operating suites, and special care areas are sorely in need of modernization. Ambulatory care space is limited. It creates crowded conditions and poor patient flow.

"Additionally, we have considerable parking deficiencies, which definitely impacts our recruitment ability of scarce personnel."

During fiscal year 1988 my medical center utilized $800,000 of non-recurring monies to fund current operating needs.

At this time I am really unable to provide you any realistic estimates on my FY 1989 budget because I don't have all of the information on what my budget will finally have at this time.

I will close by saying that although we have been facing many challenging problems, we have provided and will continue to provide high-quality care to our veteran population.

Mr. MONTGOMERY. Thank you, Mr. Jenkins. I want to thank all the members of the panel for their good statements.

Because of time, and the fact that we have three other panels, the chairman will try to set the stage and I will only ask two brief questions, and I'd like brief answers from the panel members. If you can, please just answer yes or no. And then I will move to those who like to be recognized. But these are very, very important witnesses, and we don't want to cut the time when it is necessary to get exactly what we need to know.

My question is: are you turning any veterans away on account of lack of funds. I guess we'll start with you, Mr. Jenkins.

Mr. JENKINS. No, sir.

Mr. MONTGOMERY. What?

Mr. JENKINS. No, sir, we are not.

Mr. MONTGOMERY. You're not turning away any veterans?

Mr. JENKINS. None at all.

Mr. MONTGOMERY. How about you, Mr. Fears?

Mr. FEARS. Every veteran who comes to us we make sure that he's taken care of in some manner or form. We are turning some away if they are able to get their care elsewhere—through Medicare, for example—if the wait would be too long for us to feel comfortable with them waiting for us to deliver the care.

For example, we have referred approximately 25 heart patients surgeries to other hospitals that came to us for care, but since they had eligibility elsewhere we were able to talk to them and they were able to go across the street and get that care.

We have also done things such as delay surgeries that are expensive if they require some sort of a prosthetic device. We will take care of them eventually, and they are not emergency care that's needed right now.

Mr. MONTGOMERY. But let me get this clear, Mr. Jenkins. You don't turn anybody away? You don't tell them to come back in 2 months?

Mr. JENKINS. Oh, yes. We have delays. I concur exactly with the comments John is making.

Mr. MONTGOMERY. Well, that's very, very important. The problem that is developing is that you are turning these veterans away and telling them to come back for eye checks in 2 months.

Mr. JENKINS. We do that.

Mr. MONTGOMERY. You do that?

Mr. JENKINS. Yes.

Mr. MONTGOMERY. And the problem is that they're going to the private sector.

Mr. JENKINS. We have waiting times for all of our clinics from 1 day to as long as 2 month.

Mr. MONTGOMERY. 2 months?

Mr. JENKINS. Yes, sir.

Mr. MONTGOMERY. You do turn them down on that day on occasion?

Mr. JENKINS. Yes, sir.

Mr. FEARS. An effective way of rationing care is to give somebody an appointment 6 to 8 months in advance.

Mr. MONTGOMERY. Well, that's not good news.

Mr. BILIRAKIS. Mr. Chairman, I hope I'm not out of line, but I just wondered where—you said you turned away 25 heart patients because they could get better care or adequate care?

Mr. FEARS. No, sir. They would have had a long wait if they had to wait at Hines. So what we did is talk to them and point out that they were eligible for Medicare and that they could have the same procedure done by the same physician if they went across the street, and they took advantage of our kind offer.

Mr. BILIRAKIS. Was there any follow-up on those 25? What I'm wondering: if we're concerned about proper medical care for our veterans, it should be proper medical care. I'd like to say regardless, but I know that our emphasis is at the VA centers. I'm not trying to get away from that. Any follow-up on those 25?

Mr. FEARS. Yes, sir. They come back to us for post-hospital care.

Mr. BILIRAKIS. They receive proper, adequate care?

Mr. FEARS. Yes, sir. As a matter of fact, the same surgeons who would have operated on them at the VA operated on them on the outside.

Mr. BILIRAKIS. Thanks, Mr. Chairman.

Mr. MONTGOMERY. Thank you for adding.

Mr. Ayres?

Mr. AYRES. No, sir. No emergency veterans' requests are denied. Elective situations such as you have described—elective surgery, elective hearing examinations, and others—are deferred for longer periods of time than we'd like, but nothing on an emergency basis is denied.

Mr. MONTGOMERY. How about non-service-connected veterans for out-patient clinic care?

Mr. AYRES. I have a unique situation in our area. All but 3 percent of my work load at Salisbury is service-connected. There are many service-connected veterans in the State of North Carolina—especially in the middle of the Triad. But the non-service-connected veterans, the B's and the C's, are discretionary work load, and so far we have been able to accommodate through 1988—obviously,

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from my scenario 1989 will be a fairly different situation. But we're able to take care of them in the best time we possible can. It's not acceptable, but that's the best we can do.

Mr. MONTGOMERY. I would hope you would take care of emergencies.

Mr. AYRES. Emergencies are never a question.

Mr. MONTGOMERY. Whether they're veterans or civilians we don't want them dying on the ground.

Mr. AYRES. Regardless of whether they're service-connected or non-service-connected, a critically ill or emergency case is handled immediately.

Mr. MONTGOMERY. But I'm afraid you're getting around us by delays and by telling them to come back 2 or 3 months later on. In my opinion that's turning them away and they're going to private facilities.

Dr. Musser?

Dr. MUSSER. We turn them away.

Mr. MONTGOMERY. How about that.

Mr. GRAY. Would the Chairman yield on that point?

Mr. MONTGOMERY. Yes. Sure.

Mr. GRAY. Let me tell you the experiences that I have had concerning what Mr. Ayres said. It is a question of medical judgment of whether it is an emergency or not. I've had veterans die that were turned away because they said it was not an emergency. I think you'll find an answer to your question in the medical determination of what an emergency is. If they don't think it is an emergency they turn the veteran away and he dies. I've had that happen several times at our Marion, Illinois and Jefferson Barracks facilities.

Mr. MONTGOMERY. That's a very good point.

My last question—my time is up. The Chair will go by his own rules.

Mr. SOLOMON. I wouldn't object if you want more time.

Mr. MONTGOMERY. No. No. I go by my own rules. Go ahead.

Mr. SOLOMON. Thank you, Mr. Chairman. You sure are a fair chairman, I'll tell you.

I just want to make one comment to Mr. Ayres. You talked about the Federal employee bashing, and I guess we've all been guilty of that at one time or another, particularly when we get tied up in the federal bureaucracy.

But, in addition to our staff having gone through a number of hospitals throughout the country in the last couple of months, I have also taken the opportunity to go by myself to a number of these hospitals, and I have just come away so impressed with the people at all of these hospitals—and I mean every single one of them.

So in spite of the problems that we are all having, you guys sure do on hell of a job out there and we really do appreciate it.

Let me get to a question here. Mr. Musser had talked about a $1.46 billion shortfall overall. To bring that down to an individual hospital Mr. Ayres said that there was a $2.8 million shortfall in his particular hospital. I think over in Boston or at Hines the report shows you've got something like a $5 million shortfall. Up in Albany, New York, I know I've got about a $4 million shortfall. As

I look at it, that $4 million shortfall represents what looks to me like an average throughout the 172 veterans' hospitals—forget about the out-patient clinics.

But what looks like a very small problem—two or three or four million dollars when we talk about billions around here—when you add $4 million times 172 hospitals you come up to $688 million. That's a $688 million—three-quarters of a billion—shortfall in coming year 1989 which starts in 3 weeks. Forget about the problems we've got in the last 3 months of 1988 that we've been going through here. I think this really is why we are all here today.

So could I just ask you, Mr. Ayres, what caused the $2.8 million projected shortfall for coming year 1989? Was that Dr. Musser?

Dr. MUSSER. I believe that was Mr. Ayres.

Mr. AYRES. Thank you, Wendell.

I think I cited that in my testimony a few minutes ago what additional cuts were made to accommodate the productivity shortfall, then we looked at the additional projected budget for 1989, and it is obvious that there is not the money there to cover what was originally asked for in our initial target allowance projections.

It is simply a matter of continuing escalation of costs in the entire health care arena. We're not any different than the private sector in the paying of our nurses, except we're on the short end of the stick, but you'll get to that, I'm sure, this afternoon.

But there is the traditional shortfall that has been in place since 1977 forward. We just haven't caught up. We're almost talking as if, with the inflation factors, a red-line budgets from year to year.

It is a complicated scenario which is not easily answered in a sentence or two.

Mr. SOLOMON. Mr. Chairman, the reason I bring this up—and I talked about this 100-322 piece of legislation which had the beneficiary travel statutory mandates in it, it had the state home payments reimbursements, and a whole series of nursing recruitment programs which talks about the problem we're having with nursing recruitment at Hines and Albany and other places.

But, Mr. Chairman, we've got a problem coming up here which, under our normal budgeting procedure—and I think Mr. AuCoin can vouch for this—but I think under our present rules that the Veterans' Administration has to present a budget to the Congress, and they don't do that until January.

In other words, they can't ordinarily get a supplemental, if I understand it right, until after the Administration gives the Congress a budget which we don't get until January 25. Now, fiscal year 1989 starts in 3 weeks on October 1st. That means we've operated at a deficit here for July, August, and September, which has created a problem of all of you tightening your belts, which really has hurt the medical care delivery system.

Now we're going to go October, November, December, and January—4 months, one-third of a year—before the administration or anybody can ask this Congress for a supplemental. That means we will have operated for one-third of a year at this three-quarters of a billion dollars which you all are sitting here testifying to—three-quarters of a billion dollar shortfall. Where are we going to get the money to deliver current services or to deliver the needs that we have here?

I think that we need to sit down with the Director of the Veterans' Administration, we need to sit down with the White House, and we need to determine how they can come in here and ask for a supplemental now—not January 25th.

These people sitting out here running these hospitals don't know whether they're going to get any supplemental at all, even January 25th—or by the time Congress gets around to it, February, March, or April before we give them a supplemental. What are they supposed to do? Are they supposed to act illegally and spend the money they don't have to deliver the services in Boston or Albany or wherever? They can't do that, Mr. Chairman, and that's why I think we've got to sit down somehow and rearrange this whole budget projection or we are in desperate trouble in our VA system throughout this country.

And that's not Tom Turnage's fault. That's not your fault, Mr. Chairman, or mine, or anybody else's. It's the system we're operating under. We'd better do something about it, so let's think about that as we progress on through this hearing here today and decide what we're going to do about it.

Mr. AuCoin. Would the gentleman yield?

Mr. Solomon. Yes.

Mr. Montgomery. The gentleman's time is up, but the chair will recognize the gentleman.

Mr. AuCoin. I realize I am a guest of the committee, so if there are committee members, Mr. Chairman, who would like to question the witness I would certainly yield to them. I wanted to just tie in on——

Mr. Montgomery. That's fine.

Mr. AuCoin. I appreciate that, Mr. Chairman.

I think that Gerry Solomon is making an extremely good point, and I don't know how we mobilize on a bipartisan effort to try to accomplish the goal he seeks, and which I share.

The corollary question is: how did we end up getting waltzed into this position in the first place? I come back to my original point. When a budget is submitted, it is submitted on the basis of certain expectations.

I sit on the Appropriations Committee. I see the budget justifications of the agencies I serve under. When a $10.3 billion budget is submitted to—which is what the VA's budget request was for this year—when it is submitted there is a series of budget justifications which indicates what the policy result will be from Congress' agreement with that number.

In this case, this last year Congress actually improved that number by about $217 million. What I'd like to know is: why do we find ourselves in a situation where we find out now, the fourth quarter of this year, that all of these wrenching problems are occurring?

Escalated costs have been mentioned. I'm not trying to pick on any policy-maker at VA, or certainly any operator of a hospital, but I'd like to know who, in making the calculations of estimated costs and the assumptions of inflation in those costs when the budget was being prepared—Congress gave you what you asked for, and then some, to the tune of $217 million. We did so thinking that there would not be people who are contracting for nursing home

care given 2 weeks notice that they had to get the hell out of their bed. Now we're finding out in the fourth quarter of the year that they are. We're finding out without much notice, as Gerry Solomon said, that all of these cuts are taking place.

I think there is a real problem somewhere, and I'd like any of the hospital operators to give us some input on this. I'd like to know what kind of information you give to the folks at the top to prepare these budget submissions to OMB, because something is very wrong in the budgets that are being submitted. We've improved on those budgets, and still we find ourselves in the situation. That's the first question.

The second question is: why is it that if everything was moving along without chaos until the fourth quarter, how soon did you know that these problems were going to occur, and did you tell the VA here in Washington about the problems that you saw within your own institutions, because what we suddenly find out all across the country at the 11th hour—forget the 11th hour; this is 11:45, 15 minutes to midnight—that these catastrophic kinds of wrenching, chaotic experiences are going to be inflicted upon veterans across this country.

So the question of when you knew that that was going to be the case that these cuts were coming is relevant. And did you then, as operators of hospitals, tell your higher-ups in Washington?

Mr. FEARS. I can answer for myself.

Mr. AUCOIN. Mr. Fears. would you like to speak to that?

Mr. FEARS. The answer is yes.

Mr. AUCOIN. You did tell them?

Mr. FEARS. Yes, sir.

Mr. AUCOIN. What were you told? Were you told to announce this or to let anyone know about it?

Mr. FEARS. My job is to operate a field facility and to let my superiors know what problems I incur while doing that. Starting with the fiscal year 1987 budget, when we first got the target allowance I informed my superiors exactly where the shortfalls were and what I would have to do to meet those shortfalls.

Mr. AUCOIN. Did they tell you to wait until the fourth quarter to do that?

Mr. FEARS. They told me that my job was to take the funds that had been given to me and to use them to the best of my ability, which I did, which brings me to that question.

The way we have done this—the way most hospital directors have taken care of this shortfall—is use non-recurring dollars to meet recurring needs. That is: we have taken the pot of money that we get for equipment and the pot of money that we get for maintenance of our facilities, and we have thrown it into salaries. Now, when we run out of that money, that's when we start getting into trouble.

This year some hospitals, in my understanding, had used all of their non-recurring dollars, had used all of their recurring dollars, and now, as we come to the end of the year, they're literally starting to run out of money.

Fortunately, I haven't run into that situation; however, I have spent, in the last 2 years, over $4 million in non-recurring monies to meet the needs.

That's really pushing you into a deep hole. It's like you're eating off your arm to feed your body, because next year we won't have the equipment, and everything will be in more disrepair, and it is just a spiral that is going downward that I don't know how we're going to get out of.

Mr. AuCoin. Of course it does. And it does one other thing, and that gets back to the point of when Congress has notice, which is the point Mr. Solomon made and which I strongly agree with him. By doing that, by using non-recurring to pay off your immediate expenses, you allow for a long period of time until it gets down towards the end of the fiscal year and the end of Congress.

Things can be floating on a fairly normal basis, and then the bottom drops off—just like my time ran out—and Congress is finding itself right up——

Mr. Montgomery. I'm going to send you back to Appropriations Committee.

[Laughter.]

Mr. AuCoin. Congress is finding itself up against adjournment, and then you get into the problem of the supplemental in the next year. So I really think this is a problem—a significant problem.

Mr. Montgomery. I think you hit the nail on the head, and actually what you said is what the survey has said. It said that you're robbing Peter to pay Paul. They're taking the money from maintenance and other accounts, and this is what the survey has proven of all the veterans' hospitals.

The gentleman's time is up.

Roy Rowland?

Dr. Rowland of Georgia. Thank you, Mr. Chairman. I want to beat this dog a little bit more.

I have my opinion as to why we have gotten into this situation with this $800-plus million shortfall, and i have heard many of the things that you have said about why you think it happened, but let's get right down to the real basic reason.

Going right back to the very basis for this, what, in your opinion, is the basic reason for us having this shortfall that we have now? And I don't want to look at a tree; I want to look at the forest.

Dr. Musser. I am going to grow you a forest right now, Dr. Rowland. We're looking at accumulation over a number of years of excellent entitlement legislation that was not followed up by appropriate appropriation bills.

I remember in 1971 when I was the ACMD for planning and evaluation for the Department of Medicine and Surgery during the Nixon Administration, and we did a study of the shortfall of dollars necessary to adequately put forth the entitlement care to the eligible veterans, and we were $1.2 billion short then. That was 1972 when Rufus and I used to do the St. Louis Waltz at 810 Vermont.

So this is a cumulative sort of thing. The problem is that certain deficits occurred years back. They accumulate. They roll over into the next year, and they continue to roll over and over.

So it is not something that began. It is kind of pointless to start pointing the finger at somebody. It is a historical phenomenon that has occurred to us that the dollars have not fit the legislation that entitled people to care. The dollars did not face the changing tech-

nology. The dollars did not address the escalation of costs. The dollars did not address the most tragic epidemic in American medicine called AIDS and on and on. The dollars did not address the identified need for the identified population.

Mr. FEARS. I've got a more direct answer. I'm going to get in trouble for saying it. I think it's a communication problem, and I don't think the Office of Management and Budget transmits the needs of the veterans and our needs to you for the appropriation.

Dr. ROWLAND OF GEORGIA. If you get in any trouble about saying that let me know.

Mr. JENKINS. Dr. Rowland, I want to make two comments. One of the primary reasons I believe we are in the trouble we are in is our inability to keep up with the inflation costs and increased costs.

Normally our budgets will run anywhere from as little as 3 percent to four, five, or 6 percent at the most to deal with inflationary costs, and I know in the last ten to 12 years we have seen times when we had 15 to 20 percent increased cost in medical care. That, to me, is one of the biggest factors we face.

In the most recent years—at least in my facility—1 percent productivity item that we faced every year is approximately $600,000 and 20 FTEE in my facility, so that is about $2.5 million just in the last 4 years out of my recurring base that I've had to give up.

Dr. ROWLAND OF GEORGIA. That productivity improvement cuts that came about was for what reason?

Mr. JENKINS. It was passed on from OMB.

Dr. ROWLAND OF GEORGIA. Okay.

Mr. AYRES. Dr. Rowland, I believe that Wendell has summed it up very clearly. Plus you can add into that a couple of continuing resolutions which Mr. Solomon mentioned. When you get half-way into the fiscal year then your money is restored at a different level than you anticipated. It compounds the situation.

Even though we are anticipating having a budget this January, we still don't have any idea what that budget is really going to represent.

We also have another problem. I believe one problem is the insatiable appetite of the teaching facilities. This situation has been compounded by the drying up of soft money that traditionally supported education, and education that we need in the long-term care and the small hospitals.

But also these are very difficult times for managing, and I must commend my staff in the hard-nose attitude we have had to take in these last few years. We have been able to live within our budget without affecting M&R, without affecting the non-recurring accounts, because you should never, if at all possible, damage the non-recurring accounts—such as non-recurring M&R—because once you lost your physical plant it is gone.

This committee has worked hard, along with the Department of Medicine and Surgery, over the years to ensure new construction which we badly need with the AIDS epidemic, Alzheimer's, and so forth.

I'm in a unique situation at Salisbury, but I think one of the things that need to be addressed separately is the affiliation and the needs of the teaching hospitals.

Dr. ROWLAND OF GEORGIA. Let me just—my time is up, but we heard from a couple that OMB played some part in this.

Mr. MONTGOMERY. I think one of the problems is that OMB didn't ask for enough money when all of this started out. Over the years they really haven't asked for enough to run the Veterans' Administration medical care, and then they don't come in and ask for supplementals, which other agencies get and we don't get. We all add a little money in appropriations and authorization committees, and that's where our problems are.

Charlie Stenholm of Texas? Charlie, thanks for your patience in being here today.

Mr. STENHOLM. Thank you, Mr. Chairman.

I don't have any additional questions. It has been very refreshing to listen to this panel and my colleagues discuss the problems that we have today.

It is always nice to bash OMB, but I can't help but remind myself why I am here today. I have a VA hospital at Big Spring, Texas, and you folks have spoken eloquently on behalf of my administrator. Possibly Big Spring is now delivering services a little better than you are within the budget restraints based on what you have stated today. They have accepted the challenge of the squeezing budget and have done it just exactly like you're doing it today, and we're pushing ourselves into a corner.

The reason that I switched from the Small Business Committee to the Veterans' Committee is that I saw what was happening to veterans' health care. I also saw what was happening to health care delivery in rural America. And we're talking about the same problem.

We talk about a $700 million shortfall today. Just wait until early 1900's when we've got a multi-billion dollar shortfall in Medicare and we're going to dance around that one as we have been dancing today for the same reason the gentleman said earlier: we have over-promised entitlements.

The bottom line is that there is not going to be the money to deliver all of the promises that we have made to everybody in this country.

We must look at the promises we've made to veterans at a higher priority than the promises we have made to every one of the rest of us as we approach that magic date called senior citizenry, which is my number one goal in life today.

[Laughter.]

Mr. STENHOLM. But the bottom line is that we have over-promised in a lot of areas. Let's remember that we've got $700 million total left to spend before we get sequestration.

So I'm a little uncomfortable that I'm here today, but we are here, and we've got a real problem. But the solution to it is not going to be quite as easy as I think a lot of us would like to see it.

I've had five hospitals close in my district during the last 2 years. We've probably got that many more on the chopping block right now. Closed. That means zero health care available within a 30 to 50 mile radius.

The formulas used under the DRG system are about to put rural hospitals out of business. Regarding my colleague's earlier remarks, I'd like to be able to offer a $37,000 salary to a registered

nurse. We could entice some folks to drive 100 miles for that kind of salary out our way.

I think the RAM system is probably just as poor as the DRG system. But what are the alternatives?

Mr. Chairman, I've spoken enough on the problem. I look forward to being a part of the solution, and I think we've really got to roll up our sleeves on this committee, and I know under your leadership we will, and look ahead to next year. We are beginning to realize that we've got some problems, and they're not going to be solved easily, and it is a total health care problem, and it is a prioritizing problem we're talking about on this committee.

As has been pointed out, we are usually successful when we prioritize, but it is time that we started looking at the real problems we have in total health care delivery. Plug in the veteran at the top of that list and then working down and take the available resources that we've got.

Mr. MONTGOMERY. I want to thank the gentleman for his thorough and comprehensive comments. We do have problems, but I think over the years, Charlie, that we have tried to be moderate conservatives on this committee.

I get knots on my head because we don't bring out a number of bills that would just about break the treasury or break it some more. It is just a matter of, as we said earlier, priorities and what we figure we should get.

Go ahead.

Mr. STENHOLM. You bring that out, and the chart you displayed shows that.

I have the privilege of serving as the Chairman of the Subcommittee on Livestock, Dairy, and Poultry. We have some very, very important responsibilities dealing with food safety and the health of our citizenry. I have heard the same appeals for a supplemental, and during my years of service in Congress I would of loved to have an agency of the Federal Government come and tell us they can accept it and live with it without having an increase. The trouble is that nobody says that.

But I think what we're seeing now is that the proof of the pudding is in the eating. When you look at a line like that and you squeeze it for 8 years you have squeezed the fat. At some place OMB has got to accept the fact you can squeeze no more from certain areas, and we in the Congress have also got to accept that fact and start maybe doing a little harder job in fighting for those priorities which we might agree among ourselves need to be done. But we can't do it for everybody.

Mr. MONTGOMERY. Well said.

The time is up for the gentleman.

Claude Harris of Alabama?

Mr. HARRIS. Thank you, Mr. Chairman.

You know, I guess one thing that troubles me as much as anything about the problem is that if we are talking about building more facilities in certain areas when we don't even have the staff to staff the facilities we already have, that's troubling to me. It would be like my wife wanting to add more rooms when we can't even furnish the ones we have.

So I understand that you've got your budget divided in different areas, but it seems to me that what several of these gentleman are saying is making sense. You're going to have to start looking at more flexibility. It makes no sense to build a new building when we don't have enough doctors and nurses to work in the buildings that we have already.

I appreciate the candor of the gentlemen before us. As several folks have commented and talked around about, probably the folks from OMB need to be here too, because the problem is that when we have our budget and we feel like maybe enough money is being asked for to start with, and then having to put something in that has been asked to be taken out, it puts you in a problem of trying to compete for those scarce dollars if we are not asking for enough to start with.

I don't know what you gentlemen asked in your budget, and probably if you could just give me some roundhouse figures, what are we talking about for 1989? Do you know how much your facility asked for as far as money overall and what you received?

Dr. MUSSER. The deficits of record that have been recorded in the past are not really used and addressed as one is putting together the present budget, so it is difficult to take that budget, as such, and say I ask for such and such.

For instance, just to have adequate staffing I need 206 people, multiplied by $30,000. I don't ask for that in the budget because I know I'll never get it. So that is a matter of record. Now, it is in the record.

What we really do is look at work loads that we had the year before relative to the space and the people that we had and project that plus additions for new program developments that have been approved through our planning process, and that is spread in a work load.

Now, when we spread the 1989 budget and take into consideration the considerable shortfall—about a million and a half dollars right off the top in fiscal year 1989—there is really no way of really asking for the funds necessary to address our deficiencies.

But all of those other things we've been talking about are not always listed budget projections.

Congressman Stenholm said it well: it would be absolutely ridiculous to ask for what I'd really like to have to staff the hospital. I'll never get it. Never.

Mr. HARRIS. I hope you can see the problem at the other end, then, in trying to figure out how much you need when you don't know that you've been spending non-recurring money on recurring problems at the hospital. And you're going to end up one of these days when you don't even have funds to replace equipment. And if people don't know that, how in the world are you going to budget for it or try to get in and pitch against other competing areas for the money?

Dr. MUSSER. We would like to have an opportunity to present that. I cannot speak for 810 Vermont. I can speak for Atlanta, Georgia. I can speak for the experience in the organization, Mr. Chairman.

For instance, I am $1 million short on equipment. I took used equipment from Fayetteville, Arkansas, to man pieces of equip-

ment in the intensive care units in Atlanta because the amount of money is so large that there is no way that I'm going to get the money to replace those pieces of equipment.

But if someone asked me what I need in equipment, the first thing I'd do is hand him the $1 million list.

Right now there is no way that I know of for my bosses and my leaders to ask for it. We have that problem throughout our system. We have a lot of hospitals that are 22 years old that have equipment that is beginning to melt, but there is no real good way to address that as far as I know in the budget process.

A similar thing with M&R. We never really get what we need to totally address the maintenance and repair needs of an organization as large as ours—we get a portion thereof—because the entire need would be staggering—and back to Mr. Stenholm's comments again.

Mr. HARRIS. Mr. Chairman, I see my time is up. I would imaging he probably answered pretty much the way the others feel. If he didn't, I'd like to hear from them because this is a real problem. I'm certainly no expert on budget matters, but in trying to make some kind of intelligent decision, when you ask how much you need and you get a budget, but then you find out that's not what you needed at all. So it is sort of hard to make any kind of judgments.

Mr. MONTGOMERY. Thank you.

For the members who have been here, I will recognize you by the way you came in. Joe Kennedy, Bob McEwen, Mike Bilirakis and Tom Ridge. Joe Kennedy?

Mr. KENNEDY. Thank you, Mr. Chairman.

Mr. Chairman, I've only been in the Congress for a short period of time, but it does seem to me that simply blaming OMB for this kind of budget crunch is just a cop out. The fact is that I serve on the Housing Committee of this Congress. The Housing Committee started this year with a $17 billion budget. We basically passed an $11.8 billion budget, and that is, in large measure, because of OMB's efforts.

And yet every housing group in the country that is concerned about the level of funding comes in and screams like a banshee in my office about the lack of funding, and this is the first time that any of you fellows have come in here and suggested that you have funding problems.

Don't think that you are going to be punished for telling us the truth. I mean, the fact of the matter is that the reason why the Republicans and the Democrats are working together on this committee is in order to have a unified force behind the veterans of this country. I can't believe that we're sitting here arguing with one another.

Now, if there is somebody over at OMB that isn't willing to stand up to the plate and pay the funds that are necessary, I'll tell you that the taxpayers of this country are willing to pay the bills for the people that are willing to go out and defend this country.

So it just seems to me that we have got the tail wagging the dog here. At some point we have to recognize that it is all of our jobs as public servants to serve the vet.

Now, I don't want to sit here as the young fellow trying to preach to you fellows. I know that you've been here and you've been working hard at serving veterans' needs—and that goes with General Turnage and Dr. Gronvall and everybody else. But it can't be some coincidence that the number that Gerry Solomon comes up with is some $600 million or more. The difference between the budget that Dr. Gronvall gave to General Turnage is about $600 million.

What we're talking about is just being honest with one another and being honest with the American people about what the shortfall is, and then telling the people that if they want to serve veterans and stop the plaster falling off the wall, if they want to stop the fellows that are falling down stairs in Boston, if they want to help the people out in Charlie's district, if they want to help out the people in Boston, it's going to cost money.

But when I ran for Congress I read the Constitution, and the Constitution says we set the budget. So, Dr. Musser, when you suggested that somehow or another we can't find the dollars, in all fairness that is my problem, and that is every other Congressman's problem. That ain't your problem.

So you come to me and tell me. And that goes for you, Mr. Jenkins. If you've got a problem in that VA facility in Boston, Massachusetts, please let me know, but don't let us read about it in some report that the staff of this committee has to come up with, and then they are somehow considered heretics because they are willing to stand up and suggest that something is not right, when you fellows know damn right well something's not right.

So what I'm trying to suggest is that there are a lot of Congressmen—both Democrats and Republicans—that are very willing to deal with real problems that are faced in this world.

But this is some sort of barrier that exists that I don't understand in terms of your willingness to just come forward, lay the cards on the table, and suggest that things aren't right.

Les is right in terms of suggesting that the time is not right, hell, I hear all about the budget process. We've been talking about that for the 2 years that I've been here about how screwed up everything is. Well, that's fine. But that doesn't get people's attention.

Let's talk about the way that veterans are being turned away—Ken Gray just handed me a note that showed me that there is a veteran in his district that was disallowed a prosthesis for his leg. He's disallowed a false leg that was cut off in Vietnam because there's no money in the budget? I'm sorry. That's not what I was elected to Congress to do. And if I have to tax people to get them to pay for the gosh-darn leg, then I'll tax the people. But you let me decide that. Don't you and the administration decide that or you and OMB should decide that. You let us know and let us carry our water as well as asking you to carry yours.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Joe.

Mr. SOLOMON. Don't be so wishy washy.

[Laughter.]

Mr. MONTGOMERY. You were within your time. You're learning. Bob McEwen?

Mr. MCEWEN. Thank you, Mr. Chairman.

I have a question for any of you gentlemen. Is the practice of shifting funds from one account to another to meet changing budget priorities a new phenomenon, or is that a tradition?

Dr. MUSSER. Of course it is not new. We've done it for years.

Mr. MCEWEN. Is it normal for a manager in your position to have this kind of flexibility?

Dr. MUSSER. I think so.

Mr. FEARS. If we didn't have it we wouldn't have made it the last couple of years.

Mr. MCEWEN. Is it traditional at this time of the year to run short of budget and to transfer accounts?

Mr. FEARS. No.

Mr. MCEWEN. How does this year compare with other years?

Mr. AYRES. For me it is about the same, but we do need the flexibility and require the flexibility to shift money around not only at the fourth quarter, but to meet the demands of our work load. We do not have control of that work load. We do not know that next year will bring us a 50 percent increase in AIDS or Alzheimer's. We have to be able to adjust those work loads.

When your house is full—and we run 88 to 94 percent occupancy at Salisbury—I have to depend very heavily on community nursing homes, and we ought to be able to shift money to accommodate that work load going from the acute beds to the nursing homes to free the acute beds.

Mr. MCEWEN. Mr. Fears, at the end of the fiscal year how does your shortfall compare to previous years?

Mr. FEARS. The last 2 years have been horrendous. Prior to the 1987 and 1988 budget I didn't have to shift any dollars from nonrecurring accounts just to pay the bills. I always have shifted a few to meet the needs of the veterans.

For the last 2 years I have had to shift close to $2 million a year into accounts——

Mr. MCEWEN. From how large a budget?

Mr. FEARS. From $140 million.

Mr. MCEWEN. So that's less than 2 percent.

Dr. Musser, how about you?

Dr. MUSSER. This has been the most difficult budget year that I have faced in my 27 years in the organization.

Mr. Chairman, please, I must have ten seconds.

Congressman Kennedy, I don't want your job because I couldn't do it. Just don't put out the fire after I have been burned.

Secondly, no one has ever intimidated me in the multiple times I have testified before the House and the Senate for the benefit of the veterans. No one has contacted me with any implied threat of any sort. And I pride myself on being able to make a——

Mr. KENNEDY. Mr. Fears said that in his testimony not ten minutes ago.

Dr. MUSSER. I'm not speaking for Mr. Fears, Congressman. I'm speaking for myself.

Mr. FEARS. I am sorry. I would apologize for the remark. It was really made in levity.

Mr. KENNEDY. It is not the kind of remark to make in levity.

Mr. FEARS. I apologize.

Mr. McEwen. I appreciate that very much, because we are interested in whether or not we can get the facts.

Congressmen are very good at what we are able to do. We set the parameters, and we say we're going to spend this much in each category. Now, OMB, you go back and work out the budget, and you forward the budget up here, and then when you send the budget up here we will pass it and then we'll turn around, and if the VA is not around and we're touring the VA facility we will say that the VA doesn't spend nearly enough money here, so we bring the VA in here and they say, "Here's your budget, and here's what you gave us, it must be OMB's fault. Let's get OMB."

And so we'll rank on them a little while, and then OMB will come up and say this is the agreement that came down from the leadership of the House and the Senate and was signed by the President. You said you didn't want to spend any more money than that, and here is the maximum amount of service that we were able to get out of the amount of dollars that you agreed to back in your summit, and you signed it and passed the budget and said that's what we had to do.

And so then we get to run out and say it is their fault and their fault and their fault, but Lord knows it ain't our fault, isn't' that good.

Now, in the process of that there are a lot of dedicated VA people that go home at the end of the day having stretched and twisted and pulled and labored and sacrificed and brought in materials from their home, and having lost weekends and having not punched in on overtime, and on and on and on. And in the process of it we don't want you to think that we don't fully appreciate and understand the constraints that you are up against.

Just as Gerry pointed out, you're going to have—a third of the way through your budget you are going to sit down as the administrator and talk to your employees with a new figure and say you're supposed to operate under these constraints and a third of it is already gone, and how are you going to get from here, and you won't get it on January 25th. You're not going to get it 5 days after the new president is sworn in. You'll be 50 percent through the fiscal year when you'll finally find out how much you're going to spend for the fiscal year.

How you do it as well as you do is beyond my comprehension, and I appreciate it tremendously. And how you keep the morale among your staff when the physical conditions of the plant are many times deteriorating is also commendable. You make those choices and you pick and choose and try to not repair that conditioner in order to get the new equipment for the emergency over here, and it is a difficult task, and I respect it and appreciate it.

I think what we're trying to say to all of you is that the only way that we can do it better and do it well is to send up the red flags periodically and say we're doing our best, but there are no more places to squeeze. The air conditioner can't be delayed any more. You're going to have to replace this piece of equipment here and there so that we can then do our job better.

Our conclusion would be that for administrators and personnel in the VA that do what they do, God love you and we appreciate it.

Mr. Fears. Thank you.

Dr. MUSSER. Thank you.

Mr. AYRES. Thanks.

Mr. JENKINS. Yes, thank you.

Mr. MONTGOMERY. Thank you, Bob.

The Chair might have mislead Mike Bilirakis and Tom Ridge. A few members came back in—Tim Penny and Chris Smith. I thought they were gone, so without objections Tim Penny will be recognized for ten minutes.

Mr. PENNY. Thank you, Mr. Chairman.

I have listened to your testimony, and it is evident that at most of our facilities there have been decisions made in the last few years to cut back the number of beds, to borrow from one account to cover another account, to increase the number of patients served by the nursing staff, and that the work load has increased. And you have made do in a variety of ways.

As administrators, would you be able to improve health care in your facility if you had the authority to decide certain services that your facility wouldn't provide and then devote those resources to other services so you can do a better job?

Right now we expect you to be kind of an all-purpose health care facility, and as such you kind of scrimp and borrow and do the best you can to continue to provide all those services.

Can you think of certain programs or services within your institution that you would simply discontinue if you could as a way of saving what scarce dollars you have to do a better job in the services that you retain?

Dr. MUSSER. Yes. We have tremendous flexibility and opportunity as we are now constituted to determine our mission of our individual hospital and to determine from a programmatic standpoint what elements will fuse together to satisfy that mission.

I can't speak for the group, but I feel like we have excellent freedom in that area.

Now, the second part of that is that intermittently programs are foisted upon us that may not have the highest priority commensurate with out mission, and if we could we would like to say heck no, I don't want to get into that business. I'm trying to do neurosurgery as well as I can do it. I don't want to take part in this new venture.

Again, that's a mission decision which we have great freedom to decide because most of that is decided by a professional group that says that these programs are necessary in order to take care of the needs of the population we are serving.

Mr. AYRES. Yes, I think we all have to take a look quite often at our programs we have at each medical center. There is no question about it. I think as time goes along there are programs that have lost their importance and new ones that need to take their place. We've all seen this in our community with hospice, AIDS, and different other programs like this. Certainly there are some at the bottom of the spectrum.

We do have a vehicle in which we can address these, and this is our planning boards within our regions which we try to get together, and in order to prevent duplication of costs one hospital specializes in this, and one in the other reduce the costs.

At the same time, I think we could use more flexibility at a local level to discontinue programs.

Mr. FEARS. Because of the shortfalls that we see next year we have already looked into reducing several programs. I can give you some ideas.

Mr. PENNY. Could you give us some examples?

Mr. FEARS. Sure. I talked about reducing our dialysis treatment program by 50 percent, closing 30 alcohol treatment beds.

Mr. PENNY. Okay. And when you look at those options, how do you make that judgment? Do you contract out for those services, or——

Mr. FEARS. Well, actually the——

Mr. PENNY. You make a referral to another facility within a reasonable distance?

Mr. FEARS. Because of the fact that end-stage renal disease is picked up under Medicare, we would selectively refer a lot of our patients out to be picked up under the Medicare treatment program.

We will actively solicit dialysis treatment centers that will treat the veteran so it wouldn't cost the veteran anything.

The alcohol treatment would just be an arbitrary thing that we would just try to more selectively treat our patients and probably wouldn't take care of some of the guys who would walk in the front door.

A drug treatment program we're talking about consolidating with another Chicago hospital. We have about 25,000 drug treatment out-patient visits a year, and we're talking about consolidating with another hospital to hope to get some economy of scale.

The problem is that our drug treatment program treats the suburban veteran, the West Side Hospital treats an inner-city veteran, and that's why we haven't done it before, but we may just have to do that.

Mr. JENKINS. I would agree with John. There is no question. It does offer some flexibility.

We're consolidating, as of October 1, with the out-patient clinic in downtown Boston. We also have three other hospitals within a very short commuting area so we don't duplicate services. So we have some flexibility.

As John said, I think it would even offer some more flexibility.

A couple that we've talked about are the same ones that John has talked about—the drug/alcohol and dialysis.

Mr. PENNY. Thank you for your responses.

I have no further questions.

Mr. MONTGOMERY. Thank you, Mr. Penny.

Mr. Smith of New Jersey?

Mr. SMITH OF NEW JERSEY. Thank you, Mr. Chairman. I do have one question for the directors.

Do fewer beds in service mean fewer veterans are being treated, or is there an offset because of shorter hospital stays and more reliance on the out-patient services? Do you have fewer beds that are in service at your facilities?

Mr. JENKINS. Yes, I have a considerable number. I have almost 200 closed because of nursing shortage. We're treating almost a third fewer patients this fiscal year than in fiscal year 1986—

13,000 versus about 8,500. We are treating considerably more patients on an ambulatory care basis—especially in surgery.

We are treating fewer patients without question, but some of that has been taken up in ambulatory care, but not all of it.

Mr. SMITH OF NEW JERSEY. Is there an out-patient facility near your facility?

Mr. JENKINS. We have one right in the hospital.

Mr. SMITH OF NEW JERSEY. You have one right in the hospital?

Mr. JENKINS. Yes, we do. I think we all do. We treat out patients at the hospital, too.

Mr. FEARS. I think we have to be real careful in looking at just beds, because actually the Veterans' Administration now is treating more people with fewer beds, and a lot of the beds that are closed were closed appropriately because we are, for example, doing out-patient lens surgery. We're doing cystoscopies on an out-patient basis. We're doing a lot of the things on an out-patient basis that we didn't used to. We also have cut our turn-over rates in half.

So we're really treating more people more appropriately now than we were 5 years ago.

Mr. AYRES. The same thing applies. My work load is consistently up. My occupancy rate, as I alluded to, was 94-plus, and consequently the out-patient work load is up. But I do not see this diminishing because of the demands for care from the age group of the veterans in our service area.

Mr. SMITH OF NEW JERSEY. It has been alleged that some of the Category A patients have been turned away from some of the VA centers. Has that been your experience?

Mr. FEARS. I have not, but I did hear one example that was read earlier that I understand did happen, but that has been straightened out.

Mr. AYRES. Not to my knowledge.

Mr. JENKINS. We are not turning away Category A patients for in-patient care. They could be scheduled and subsequently admitted, but as an in-patient they are being taken care of.

Mr. SMITH OF NEW JERSEY. Thank you very much.

Dr. MUSSER. We're turning away Category A patients.

Mr. SMITH OF NEW JERSEY. You are?

Dr. MUSSER. Yes.

Mr. SMITH OF NEW JERSEY. Tell us why?

Dr. MUSSER. Very simple: smallest urban hospital in the United States with the highest concentration of veterans per bed in the system. Specialty clinics are, for the most part, 100 percent service connected. And when an A patient needs care we try to find him, and there is not room at the inn. We're not talking about in-patients. We're talking about out-patients.

We find him care. We find him care in a nearby VA, we find him care in the community program, if he is eligible for the indigent hospital downtown—1,000 bed hospital in the middle of the city—we utilize that. This is just a reality of an exploding metropolitan area, a large city that the VA development has not kept up with.

Mr. SMITH OF NEW JERSEY. Thank you.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Smith.

Mr. Bilirakis?

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Musser, basically your answer, then, to Congressman Smith's question is that you have turned them away in terms of actually having treated those people at the VA Medical Center, but you haven't turned them away in terms of medical care?

Dr. MUSSER. That's true.

Mr. BILIRAKIS. Is that basically the answer that—I know we've gotten that answer from Mr. Fears earlier. Is that basically the answer of all of you? Mr. Ayres? What are we saying? You have turned them away, period?

Mr. AYRES. I have not turned any away.

Mr. BILIRAKIS. You haven't turned any away.

Mr. Jenkins, you have already said you haven't turned any away.

Mr. JENKINS. We haven't turned any away needing in-patient care. No.

Mr. BILIRAKIS. And, Mr. Fears, you have said that in effect you haven't turned any away. You have turned some away, but you have also helped them to get the proper medical care?

Mr. FEARS. That's correct.

Mr. BILIRAKIS. And isn't that really the bottom line of all of this: proper quality care for the veteran of the United States of America?

Mr. Solomon talked at length about the supplemental procedure, and there is merit to that, there isn't any question about it. But why should we even need a supplemental bill in the first place if we follow the budget process, as I guess Mr. Kennedy said correctly, then it is basically a case of you good people being down in the field and knowing more about it than the rest of us in this Ivory Tower. Why should you not be basically the determining force of what the dollars are that would be necessary to do the job and then we'd go ahead and ask for it and we'd pass it and it's for 12 months' period of time rather than be concerned about a supplemental bill?

Now, I realize that there are going to be occasions when we might have some sort of a catastrophe taking place or something unforeseen where we may have to go supplementary. But I, for one, have not been supportive of supplementary appropriation bills in the Congress of the United States because I think we're all supposed to be intelligent people, business managers and what not. Why can't we foresee and forecast what our needs are going to be?

But quality care is really what it comes down to, and we can talk here that the Congress has mandated many things. We mandated and made a change here and mandated a means test. We did it because we thought we were basically going to what was just better service for the veteran in general. An awful lot of veterans who are non-service-connected and who are not over age 65 who were not in that particular category in the past—we did it for many things. We mandated these things to you.

We've mandated 100,000 beds as a minimum. We have mandated all sorts of things to you people, and hopefully we give you the dollars to go along with it. If we don't, again, as Mr. Kennedy says, you have got to let us know, and certainly not at the 12th hour, but certainly well in advance you've got to let us know.

I'm not concerned about statistics. I know we closed 13,000 beds. That sounds terrible, and it probably is, and I think it is. But where have they been closed? Are they critical beds? I know that there are hospital medical centers in some parts of the country that do not have 100 percent occupancy, and I know many—particularly in the southern part where we have—and I lovingly say—the "snowbird" veterans coming down who tax our facilities. Certainly in Florida that is the case. So it is a case of where it takes place.

Mr. Penny, who has left, talked about flexibility, I think, and I oftentimes wonder if we give you enough flexibility.

Mr. Chairman, I visited a medical center just last week, and I went to the neurology ward there, and the head nurse—I guess that's what she was. She was certainly a very bossy lady——

[Laughter.]

Mr. BILIRAKIS. She proceeded to advise me that if they had the flexibility to have a better form of home health care for those neurology patients who are still going through the healing process, they need no longer be in the medical center. But somebody has got to be with them, and if there is some flexibility whereby we had VA funds to pay certain trained individuals to go to their homes and take care of them it would cost considerably less as far as the treasury is concerned. Things of that nature. I wonder if we have proper flexibility.

I am not asking any questions. God knows I have taken up virtually all of my time. But I guess what I am saying is that there certainly is a problem here. And it has got to be addressed. And money is not the sole answer; it is only always part of the answer.

I just wonder, Mr. Chairman, if it doesn't take some sort of a task force to really dig into this thing, take off our coats, roll up our sleeves, and get together with some of these people that are in the firing line—Dr. Musser and the others—and find out really what is happening in the grass roots.

I know the committee has made efforts towards this end, and I commend them, but there have got to be more flexible ways whereby we can provide the quality service.

Mr. Fears talked about Medicare. We avoid an awful lot of subjects, just like we've avoided means tests until you were courageous enough last year to finally tackle it. And we avoid an awful lot of those subjects, and I wonder if we shouldn't be considering all of those things in addition to flexibility among the directors so that we can solve this problem, if not within the dollars, certainly within the realm of dollars if they are reachable by us.

Thank you.

Dr. ROWLAND OF GEORGIA. Well thank you. We must remember that we have got the largest health care system in the United States in the free world. The Mayo Clinic has had a lot of problems. It is good that we are try to solve these things, and I think we are all trying to pull together and come up with some answers.

This hearing is certainly pointing out today the many problems that we do have.

Tom Ridge, and then Ken Gray.

Mr. RIDGE. Thank you, Mr. Chairman.

Gentlemen, one of the questions I'd like to talk to you about is the appropriateness of using beds as a barometer of the need for additional funding and staffing and other things at the VA center. I know a lot of the private hospitals are under-utilized in terms of their beds just because of improved technology, improved out-patient techniques.

So when I see a headline that says, "VA cuts back on 13,000 beds," or whatever the headline purports to demonstrate, I'm wondering if those who can understandably be critical of the shortages within the VA are using the right barometer to emphasize their point. Are beds really the point, or is it personnel and equipment?

Dr. MUSSER. I think most of the time the beds are a red herring, a non sequitur in the whole subject. Certainly a certain minimum levels of beds is necessary for development of the backup for program. For a long time HEW has had the formula approach to this sort of thing. In years past—25 years ago or more—we had similar formulas in our system.

But once you get beyond that, the beds are not an issue as far as I am concerned. Episodes of care, the full spectrum of care necessary to address the essential episodes of care to deal with the individual problem of that patient, and ofttimes his family, that's the name of the game. That's where the action is, and that's where the resources are consumed. That's our approach to comprehensive health planning, and I think we in the VA should be very, very proud of what we have done in that phase.

So I think we take the bed issue and blow it all out of kilter, in my estimation.

Mr. AYRES. My understanding on the beds: a main factor in establishing the 90,000 beds is that we are the main backup for a terrible situation should we ever go to war or another national calamity of some type, but I agree exactly with Dr. Musser.

Mr. FEARS. I agree. I don't think beds are a good barometer.

A good barometer I think is to look at the total number of patients treated, look at the nursing hours that we have per patient, look at the number of physician hours we have per patient. Some of those things are much, much better barometers. Look at the equipment dollars that we are able to spend. Those things I think are a lot better.

The bed issue—as my chief of surgery tells me, "I don't cut on a bed, I cut on a patient."

Mr. JENKINS. I totally agree with John's comments. The only comment I would make is that I think there are some of us—and I'll speak for myself—who probably have more beds closed than they would like closed. I would like to open some of my beds because I have a need for them, but I don't think bed is a good barometer. I concur with those comments.

Mr. RIDGE. In following that up, I know my friend and colleague from Massachusetts and I, and some of my other colleagues on this committee, are entertaining the legislative notion of giving—we talked about flexibility—giving the directors more flexibility to raise salaries to attract nurses.

But having listened to your testimony, my sense is that if we don't accompany the flexibility with the dollars on that line item we really haven't done anything for you. In a sense we have given

you not necessarily an entitlement, but a flexibility that you cannot use. Is that correct?

Mr. FEARS. That's correct.

Mr. JENKINS. That's true.

Mr. MONTGOMERY. Yes.

Mr. AYRES. Correct.

Mr. RIDGE. I think that I join with the rest of my colleagues in feeling that we must address your shortfall for fiscal year 1989 as soon as we possibly can. It must be extremely difficult not only to operate—I don't know how many successive years you have had to operate under continuing resolution, but even if we pass all 13 appropriations measures this year and you have a budget, you have already told us that there is a severe shortfall, and I look forward to working with you and with the committee chairman and vice chairman to try to address that before January of 1989.

I thank you for your responses and your candor.

Mr. MONTGOMERY. Before I recognize Ken Gray I want to put in the record that I do have a letter from—well, it is a request that I made to the VA hospital in Jackson, and I have six names of veterans who were scheduled for surgery at the Veterans' Administration Medical Center in Jackson on August 17th that came to the center only to find that there were not enough beds available.

I guess my point is that beds do count, and they turned these six away. They were delayed to a later time. Does that happen to you?

Mr. FEARS. I think the question was if beds are a good barometer of how we are funded, and our answer was unanimous, I think, that it is not a good barometer. But it is obvious that if we are inappropriately closing beds and you're having to turn patients away then there is something wrong. That is a good barometer if a patient wasn't admitted to the hospital.

Dr. MUSSER. But that's a different issue.

Mr. AYRES. It is not uncommon for us to admit a surgical patient to a medical bed, have surgery, and return to a medical bed under the care of a surgeon. This happens all over the country, and we're not any different in that regard.

In order to accommodate a veteran we do mix beds.

Mr. MONTGOMERY. Thank you.

Ken Gray?

Mr. GRAY. Thank you, Mr. Chairman.

Out of deference to time I will try to be brief. I see General Turnage sitting back there and he is very patient.

Mr. MONTGOMERY. I've got bad news for General Turnage. He is another panel off.

[Laughter.]

Mr. MONTGOMERY. We're moving it along. It is a big subject.

Mr. GRAY. I'll try to be brief.

Since Mr. Fears is from Hines VA in my State of Illinois, I want to welcome him and the other members of the panel.

Mr. FEARS. Why didn't you introduce me?

[Laughter.]

Mr. GRAY. You won't be so happy when I get through with my questions.

[Laughter.]

Mr. GRAY. Seriously, Illinois has almost 12 million people, Hines, Illinois, is just outside of Chicago, in case anyone doesn't know where it is, and we have hundreds of thousands of veterans in our State.

Mr. Fears, you said something that was very intriguing to me, and I'd like you to kind of walk me through the steps, if you will.

You said a moment ago that in many cases you turn veterans away who had eligibility for Medicare. Is that not a fact?

Mr. FEARS. That's correct.

Mr. GRAY. If you're 65 or over you were probably in World War II and your infirmities probably are more severe than the average veteran from the Vietnam or the Korean Conflict.

When you send them out into a civilian hospital who pays that deductible on Medicare—$400 to $700?

Mr. FEARS. The veteran possibly, if he can afford it.

The first thing we do is give the veteran—let's say the veteran comes in and it is determined that he needs open heart surgery. We know that because of waiting lists that it may be three to 4 months before he can receive that. We tell him he is eligible for Medicare and ask him if he would like for us to refer him out rather than to wait.

If he said he doesn't really want to wait but he can't afford Medicare then what we do is try to work him into a hospital that will absorb the Medicare deductible. And we have had some luck with doing that.

Mr. GRAY. I'm sure you know the situation in Illinois that was alluded to by our distinguished member from Texas, Charlie Stenholm, and that is that hospitals are closing. We have lost 15 hospitals in the State of Illinois in the past 3 years. I held a medical summit 2 months ago, and each administrator testified that primarily the reason he was closing was because Medicare was not reimbursing him for the cost of operating that hospital.

So our years you are really compounding the problem and causing hospitals to close, as it were. You had a very large hospital just down the road from you close last week. It closed because a large percent of its patient load was Medicare patients.

I'm not jumping on my friend here from Illinois—but you can see what the problem is when a VA hospital remands its cases over to a civilian hospital under Medicare and then asks the hospital to absorb that deductible which runs from $400 to $700 per patient per admission you're just compounding your problem when you send the veteran away.

How many cases would you say you have, Mr. Fear, in that category?

Mr. FEARS. Approximately 25 heart cases this year.

Mr. GRAY. I mean all types of cases where you referred Medicare patients to a civilian hospital.

Mr. FEARS. The 25 would be the limit where we actually took an active stance on trying to refer the patient.

There are other patients who we refer through, as was alluded to before, kind of an inactive stance; otherwise, we schedule them 6 months in advance, so then they say they'll pay the deductible and they'll go out, but we don't actually schedule them in those cases.

The 25 are the only ones that we actually did that.

Mr. GRAY. So we are, in essence, saying to a large percentage, Mr. Chairman, of our veteran population that we cannot take care of the veterans needs; therefore, we are sending them out to Medicare. They could have gone into the hospital under Medicare on their own. They didn't need VA to go in and wait 5 hours to talk to someone to send them right back where they came from.

In my district the largest town we have is 25,000, so it is 300 miles from my district up to Hines. So in this case maybe a veteran went to Jefferson Barracks at St. Louis and couldn't get any help, then he goes to a larger hospital at Hines—600-mile round trip—only to be told to come back to a little community hospital under Medicare.

I think this is a terrible modus operandi that we're putting our veterans through.

Mr. MONTGOMERY. Would the gentleman yield?

Mr. GRAY. Yes. I would be glad to yield to my chairman.

Mr. MONTGOMERY. That's one of the problems I mentioned in my opening remarks, which was several hours ago. This is what really worries me. We are encouraging—not intentionally, but by Medicare and by too much delay——

Mr. GRAY. And Medicaid. That's a state-run program. They do the same thing with Medicaid. Indigent VA patients are sent out on Medicaid.

Mr. MONTGOMERY. And it worries me. In the posts and in the chapters, they say you can't get treatment at the VA hospitals, and they are going into private hospitals. We don't want that. We want these hospitals there for veterans, and we've got to correct it and do something on it.

Thank you.

Mr. GRAY. Taking back my time, Mr. Chairman, I'd say the civilian hospital would welcome it, but the VA beats them down on the deductible and says we'll send you this patient, but you've got to absorb the deductible. If they'd at least pay the $600 or $700 deductible on Medicare to make it more palatable to the local hospital, but they've got to absorb it or they are in a position of turning away that patient.

So they have been turned away from a VA hospital—a veteran—and then they are turned away from a civilian hospital because they don't have the deductible. So it is a catch-22 proposition.

Thank you, Mr. Chairman.

Mr. SOLOMON. Would the gentleman yield?

Mr. GRAY. Yes. I'd be delighted to yield to my friend.

Mr. SOLOMON. I'd just like to make a point right now. You know, a number of years ago when we were discussing third-party reimbursement—as a matter of fact, there was a lot of controversy about it at the time, but there were those of us that felt that third-party reimbursement was the way to go, and would really be part of the long-range salvation of perhaps the veterans' hospitals in this country.

At that time we were trying to include Medicare in the third-party reimbursements to VA, as we were Blue Cross/Blue Shield and all the private-sector carriers, and if we had done that at that time then the Veterans' Administration would have made up the difference of the deductible and it wouldn't have been any problem.

Mr. GRAY. I know the gentleman has always been a leader in that field. No one fights any harder for the veterans.

My time is up. Getting back to Mr. Fears and the panel, thank you very much. I know you are operating under very difficult circumstances, and, as Joe Kennedy said, I think we ought to do more here in the Congress to provide you with more money to take care of it.

But that's one area, Mr. Chairman, that really needs looking into.

Mr. MONTGOMERY. Thank you, gentlemen. Thank you, Roy Rowland.

I have a brief comment, and then we will call our next panel.

Dr. ROWLAND OF GEORGIA. Just one brief comment. I don't know why a hospital would want to take Medicare patients anyway because all hospitals—the directors and administrators that I have talked to—are losing money on Medicare. And so I don't know why they would want to take somebody in as a patient if they knew they were going to lose money on them.

As a matter of fact, you pointed out that one hospital has just recently closed because they had 85 percent Medicare patients. That is the problem.

Mr. MONTGOMERY. Well, before the panel leaves, I really think that the bottom line is that the VA has not requested adequate funds for many years—not just this administration, but other administration—and the Congress has appropriated over $1.4 billion more for the VA medical program than was requested in the last 8 or 9 years. So that is one of the problems I see.

Thank you. I appreciate very much you witnesses. You have been very helpful.

Mr. AYRES. One thing, Mr. Chairman. I think I can speak for the group that we are not under any intimidation from the central office in any way by appearing here. We were encouraged.

Mr. MONTGOMERY. Well, that's good. You can spend the night and enjoy Washington, then, if you want.

[Laughter.]

Mr. AYRES. Can't afford it.

Mr. MONTGOMERY. The next panel is Ms. Sue Hudec, who is chief of the nursing service at the VA Medical Center, Washington; Ms. Earnestine Logan, chief nursing service, VA Medical Center of Bronx, New York; and Ms. Eileen Walsh, staff nurse, VA Medical Center in Portland, Oregon.

Ms. Walsh, we've been pen pals. I believe you have written me before.

We will put your full statement in the record, so please summarize.

Ms. Hudec, you seem to be ready, so please proceed.

STATEMENT OF SUE HUDEC, CHIEF, NURSING SERVICE, VETERANS' ADMINISTRATION MEDICAL CENTER, WASHINGTON, D.C.

Ms. HUDEC. I welcome the opportunity to comment on the nursing shortage at the VA Medical Center, Washington, D.C.

Nurses at this medical center are proud to care for those who have fought to keep this country free and want to ensure our pa-

tients receive quality nursing care, even during these times of nursing and economic shortages.

It is now well documented and accepted that there is a national nursing shortage. While this R.N. shortage affects both the VA and the community, the VA shortages are more critical because of our low staffing ratios.

To illustrate this, let me share with you how the VA Medical Center at Washington R.N. staffing compares with our three affiliated hospitals, as well as the Washington Hospital Center.

Georgetown University Hospital has 1.02 R.N.'s per operating bed. George Washington University Hospital has 1.2 R.N.'s per operating bed. Howard University Hospital has 1.07 R.N.'s per operating bed. And the Washington Hospital Center has 1.37 R.N.'s per operating bed. The VA Medical Center in Washington, D.C., has 0.5 R.N. per operating bed. Thus, you can see the shortage of nurses at the VA are more serious than the private sector.

The accepted standard in the industry is currently 1 R.N. per bed. Within this crisis lies the potential for destruction of quality care for our veteran patients.

To deal with the critical staffing shortages beds have been closed, but, in addition, we still find it necessary to depend on outside agency nurses and overtime to provide safe coverage for our units. The lower occupancy rates at our medical center are not a reflection of demand for care, but reflect control of census based upon availability of R.N. staff.

VA nurses pride themselves on continuity of patient care, but with the use of agency nurses this continuity of care is lost.

With our current level of staffing we find that only the sickest patients are admitted, the discharges are quicker, and more sophisticated nursing is required. Therefore, our nursing service finds itself delivering more complex care with less professional staff and less time to provide quality care.

There is little time to educate patients before discharge; thus, many times there are re-admissions.

Nurses are no longer willing to accept these conditions for delivering patient care. Nurses are leaving the VA to go to the private sector where they have more time to deliver this professional nursing care, the nurse/patient ratios are higher and the salary and benefits are better.

We are unable to recruit the new graduates because it is widely known that you must work harder in the VA. The young graduate can no longer be wooed to the VA just for the opportunity to care for the veteran . Young nurses are more interested in how much money they can make and how the environment allows them to practice professional nursing.

To attract young graduates a facility must have minimal state-of-the-art equipment. During the past 2 years at the Washington, D.C., Medical Center our funds for equipment had to be diverted to operating costs, which places an additional burden on the nursing staff.

Computerization will permit the professional nurse more time at the bedside. This medical center has been instrumental in establishing the first Order Entry system for the VA, and when fully

operational it will decrease the amount of time spent in paperwork and increase the time nursing staff may spend at the bedside.

I, myself, am a veteran who served in Vietnam. Shortly after returning from Vietnam I went to work for the VA because I wanted to care for veterans, and the VA salary and benefits were better than the private sector. In other words, the VA was considered a good employer.

Today the VA is not perceived as being a good employer. We no longer have a competitive edge on salaries and benefits, and it is widely known that the work load is much greater.

As the Chief Nurse I am so busy just trying to give support, boost morale, and find nursing coverage within the fiscal constraints that there is no time left to plan for the future and for the improved quality of nursing care.

When nurses are not available to provide the care required it is the veteran who suffers. I may some day require the services of a VA medical center, and I want to be assured that there will be nurses available to meet my needs.

In conclusion, I would like to recommend: 1. Instant salary increases to compete with the salary increases in the community and not delayed while CO decides if funding is truly necessary are required to retain the nurses we already employ; 2. There must be provisions in the budget process for additional R.N. ceilings so we can be assured of increased R.N. staffing; 3. Continue the tuition reimbursement program which was started this fiscal year; and, 4. To provide for a bonus program to compete with the private sector.

If we are to maintain the high standard of nursing care the veteran is accustomed to—the VA needs to be perceived as a good place for a nurse to practice. I seek your support and assistance in helping us to be this so that our veterans now and in the future will receive the highest quality of nursing care possible.

Mr. MONTGOMERY. Thank you for that very fine statement.

Ms. Logan?

STATEMENT OF ERNESTINE LOGAN, CHIEF, NURSING SERVICE, VETERANS' ADMINISTRATION MEDICAL CENTER, BRONX, NEW YORK

Ms. LOGAN. Mr. Chairman and member of this subcommittee, my name is Ernestine Logan, and I'm Chief of the Nursing Service of the Bronx VA Medical Center in New York.

I want to thank you for this opportunity to share with you the pride that the nurses at the Bronx VA have in their work in trying to provide nursing care for the veteran patient.

I also want to share with you the crisis that nursing is in. The nurses at the Bronx VA are not proud of having to set priorities daily because the patient's survival depends upon it.. We are placing the nurse in this position when we are leaving them with an unhealthy, unmanageable load of deciding the type of care needed and who will carry it out.

On a regular 40-bed unit on any tour of duty you will find today, I'm sure, maybe one R.N., one LPN, and maybe three nursing assistants to care for the acutely ill patients. In the nursing home

where there are 60 beds per unit you will find almost the same numbers.

The acuity level of the patient continues to increase. Each patient who is admitted is admitted acutely ill requiring many nursing initiatives and interventions.

An agency which we consulted in New York City discouraged us from hiring them because they felt that it would be detrimental to our nursing staff who are making approximately $15 an hour to be working beside a nurse who is carrying less responsibility and making $30 to $40 an hour. We accepted their recommendation because we realized that they were right.

I can't emphasize to you enough how critical the situation is. I know you've heard much testimony today. You have heard a lot of statistics today. But the reality is that we are there 24 hours a day, 7 days a week, trying to answer why we can't do any better, and it is getting worse.

The average salary in New York City is $3,000-plus more than what we can offer the beginning nurse at the Bronx VA, and if some kind of remedy is not brought about very soon I don't know what we are going to do. When I return to New York, unless you have found some way that you can appropriate some monies so that I can start recruiting nurses I will have to make a recommendation to the director again to close beds. It is unsafe to leave the practitioner there. It is unsafe for the practitioner as well as for the patient. The ratio is much too great.

We have closed beds. We have done everything creative that we can think of except that we cannot reproduce nurses on the xerox machine. We have been asked to do an efficiency review this year to show how we can become 3 percent more efficient. Now, I'm running 40 to 50 vacancies at all times, and I don't know how I can become more efficient.

I want to thank you for your time. I want to thank you for listening to us. I feel that you are sincere in your endeavors to find some solution to the problem, and all I can do is urge you on, because it is urgent.

Thank you.

Mr. MONTGOMERY. Thank you, Mrs. Logan. Well done.

Ms. Walsh?

STATEMENT OF EILEEN WALSH, STAFF NURSE, VETERANS' ADMINISTRATION MEDICAL CENTER, PORTLAND, OREGON

Ms. WALSH. I would like to thank you also for the opportunity to attend this hearing.

As a staff nurse at the VA I am at the bottom of the health care cracker barrel. I am the one that has to do with whatever kinds of funding is received. I'm the person that the veteran sees. I'm the one that takes care of his pain.

Along with my other nurses I am the one that cleans his bottom when he is dirty, I comfort him. After he dies I am the one that comforts his family.

I am also the one that does a lot of the troubleshooting when things go wrong. If a veteran's needs are not met, I am the one that needs to check with the secretary, check with SPD, check with

prostheses to see why the veteran isn't getting the things that he needs.

When a patient is ready for discharge and his medications are not there, it is me and it is my co-workers that the veteran is angry with when his hospitalization is prolonged because what he needed was not available.

If there is a glitch or a hang-up it is my responsibility to fix it.

When a veteran hurts, if he has needs, I am the person that needs to fix it.

At the Portland VA this past summer we laid off—for the first time in I don't know how long—25 nurses because of budget cuts.

We recently moved into a new facility in February. When we moved into the new hospital it was nice for about a month or a month and a half. After that period of time, we found out that we had somehow or other gone over budget with the move, and one of our hospital wards had not opened.

We laid off nurses. We were working, on my floor, with 14 staff people total, for all shifts,for 40 beds. That meant on a day shift I frequently had 22 patients to take care of with one co-worker.

The VA acuity system has not been used in our hospital for I don't know how long. According to the VA acuity system, if I have a category IV patient—or a patient who requires a lot of care—that patient should get well over 3 hours of care during my shift. The VA is currently able to provide between 2½ hours to 3 hours per 24-hour period for those veterans.

I have seen a lot of patients get worse because they are in a veteran hospital in Portland, Oregon. Things have got to change.

I could be very graphic with any kind of examples that you'd like to know.

Thank you.

Mr. MONTGOMERY. Thank you Ms. Walsh for your sincerity and for your concern over the years about nursing in the VA hospitals.

I will be very brief as the chairman of this subcommittee.

Ms. Logan, you have mentioned that you would recommend to close beds if you can't get enough nurses. Have any of the beds in your VA hospital been closed because of health care professionals not being on the job.

Ms. LOGAN. Yes. We have closed beds. Within this fiscal year we closed 40 beds. I went to the director and to the chief of staff—I think it was in April—to tell them that I could no longer plan for care to cover the unit 24 hours a day 7 days a week.

We did an emergency closing of a 40-bed unit. Last year we also had to close a 40-bed unit because of the nursing shortage.

And, sir, if you don't mind I would like to ell you something about the kind of nurses that we have who are impacted on and who are getting ready to bail out of the Veterans' Administration.

The average age of the nurses at my hospital is 44 years old, so these are not young nurses. These are experienced older nurses.

The longevity: we have 97 nurses, or approximately 35 percent on board, who have 10 years or more of VA service. And we have an additional 58 R.N.'s, or approximately 20.3 percent, who have 5 years or more of federal service.

Just before I left I had a representative number of these long-term nurses who have submitted memos to me requesting part-

time employment because they can no longer make it on the salary that they are receiving from the VA. Many of them are heads of households, and in order for them to make ends meet they want to take jobs at other hospitals, and they can't do it if they work full time at the VA because we own them for 24 hours, 7 days a week. So they want to work part time in order to earn some of these salaries that are being offered.

The number of R.N. staff at the Bronx VA Center who are either currently eligible for retirement or will be eligible within the next 5 years is 18.2 percent.

I just wanted you to be aware that these are not just nurses who came in for a year or two and are moving on. These are our long-term career employees.

Mr. MONTGOMERY. That certainly is good for the record.

And the bed closure you have mentioned, the staff has told me that's the way it is in this book. So the form was filled out correctly.

Just very briefly of the last two witnesses: have you closed any beds because of the shortage of nurses in your facility?

Ms. HUDEC. We've had 70 beds closed for the last 2 years because of the nurse shortage.

Mr. MONTGOMERY. That's 70 beds. How is that carried in our report? Is it listed like that? We'll check it.

How about you, Ms. Walsh?

Ms. WALSH. We were unable to open one of the units in the new hospital that we had just moved into. That's 40 beds.

Mr. MONTGOMERY. Well, it is a real problem. There is no question about it. We've got to do something about it if we are going to keep the VA system running at all.

Mr. Solomon?

Mr. SOLOMON. Thank you, Mr. Chairman.

I'm just looking at the Washington, D.C., hospital, and it says that 70 beds were closed due to nursing shortage, 2 beds closed due to the pilot study, 44 beds closed due to renovation projects.

But, you know, as we go through this whole report, and just looking at the three hospitals that you represent—and especially the Bronx. I am very familiar with yours, Mrs. Logan, in New York State where I come from. But I look upstate to Albany, and even if we were to increase the salaries—which we did somewhat with the nursing recruitment in H.R. 322, we're still going to have that problem. It's not going to solve the problem, but I know it would go a long way towards helping—particularly in the Bronx.

It just seems to me that we've got to do something beyond that, because in New York City there is a tremendous shortage of nurses in the private sector, as there is upstate and in Albany, New York, and as there is throughout the country.

I wonder: why do you think that there is only a 60 percent occupancy in the nursing schools throughout this country? In other words, I can remember about 15 or 20 years ago when those nursing schools were running at capacity, and today they are down to 60 percent. Do any of you have any thoughts ion it?

Ms. LOGAN. Yes. I do, sir.

Nurses want ownership. They want ownership of their time off. They want to be able to plan. They don't like working 4 hours of

overtime or 16 hours a day. They want ownership of their own professional duties and responsibilities.

As they have increased the number of nurses and increased their salaries they have laid off the members on the support teams. So the nurse is not really doing nursing. They are picking up behind housekeeping, they are picking up behind the clerical support that is inadequate as well as the errands that must be run in the hospital.

So you don't have the support system there—the respiratory therapist to suction a person who is on the respirators; you don't have the physical therapist, the corrective therapist; and you don't have the recreation therapist.

So whom do you look for? A nurse is a nurse who can do anything and everything, and that's the way everyone seems to think. If you have one nurse there you don't need anybody else because they know that that nurse is going to meet everybody's needs, so the nurses are getting just a little bit tired of it, and we're holding them accountable for all the documentation, for patient assessment, the nursing process, patient teaching and so forth.

Then we ask the one nurse who may have 20 I.V.'s and medication for all of these patients why she didn't get the documentation done because the hospital can't get their reimbursement without it.

So they are frustrated.

So in order to keep the nurses there we are going to have to increase the support services so they can remain there and do nursing care. We don't need other technicians; we just need for the nurses to be allowed to do what they know how to do best, and that is to take care of the patient.

Mr. SOLOMON. Mr. Chairman, I know we are pressed for time, so if we can have unanimous consent perhaps we might be able to send some written questions because I have got a number of questions I'd like to ask.

Ms. LOGAN. I'd be more than happy to answer them for you.

[The information appears on p. 333.]

Mr. SOLOMON. Thank you very, very much for your testimony.

Mr. MONTGOMERY. If there are no objections the Chair will just recognize anyone who might have some questions and not go around the room. I believe that would speed it up.

If there are no further questions we will get the next panel on here.

Chris?

Mr. SMITH OF NEW JERSEY. Thank you, Mr. Chairman.

I just want to note, Ms. Logan, that you've noted that you have 40 to 50 vacancies at the Bronx VA, and yet you have been asked to find a way to boost productivity by 3 percent.

Certainly nobody ever argues with trying to find ways of boosting productivity, but it seems to me, just hearing your collective testimonies, that there is a real sense of overload—and perhaps even of burn-out. I was wondering if you can tell us what impact that is having on the nurses, themselves, and their families. I think sometimes in talking about the personnel we tend to forget that they certainly have their own problems, and if we are over-stressing them that certainly doesn't contribute to their quality of life.

Secondly, what impact is it having on the quality of care.

I was very troubled a moment ago when you said, Ms. Walsh, that veterans coming into your facility are getting worse. That is quite an indictment on the system, and if you can elaborate on that I certainly would appreciate that.

Ms. LOGAN. Well, if you can say that one nurse for 40 patients can represent quality, I really can't answer that very well. We'd like to feel that we're doing the best we can, and whatever nurse is there gives the patient 150 percent. But when we are evaluating care based on what must be done, and what is prescribed for the patient, I think we're not doing very well.

Mr. SMITH OF NEW JERSEY. The status of the health—emotional and otherwise—of the nurses, themselves? Are they——

Ms. LOGAN. Yes.

Mr. SMITH OF NEW JERSEY. How are they faring?

Ms. LOGAN. We're having more and more nurses who are coming in and requesting leave without pay—or leave because they are burnt out or stressed out. Nurses who become ill now instead of calling in for 1 day are calling in for several days. I have a list of comments regarding this from a number of the nurses, who are leaving. They are giving you all kinds of reasons as to why they just can't stay.

Mr. SMITH OF NEW JERSEY. Are you having trouble attracting even the agency nurses?

Ms. LOGAN. The agency recommended to us not to hire them because there was such disparity between the pay that the agency nurses would receive and the amount that we were paying our own nurses that they felt our nurses would walk out when they found out they were working beside a nurse who was not carrying the same load and responsibility as the Registered Nurse who was employed by the Bronx and was getting paid at least twice as much per hour. And we accepted this recommendation.

Mr. SMITH OF NEW JERSEY. Ms. Hudec?

Ms. HUDEC. We had one problem with the agency. We have a contract with the agency, and so we contract with the agency for a specific hourly rate at the agency.

We had a problem in Washington when, because we had a contract and the agency did raise their hourly rates and we were still continuing to pay what we had contracted with, the agency was paying the nurses a lower rate to come to the Washington, D.C., VA. And, consequently, at that time we had problems with the agency.

We could certainly use much more agency. We are bound by fiscal constraint on the amount of agency nurses we can use. I use approximately 430,000 a year in agency. We could probably use much more than that. The agency is able to meet our requests based on our fiscal limitations, but we could use more agency if we had more money.

Ms. LOGAN. May I just say something else? It seems ironic that we can spend this amount of money for agency nurses instead of translating those dollars into giving better benefits to the nurses who are already working for the VA. Something is wrong.

If we can bring someone from the outside and pay them much more and give them better hours and everything else than our own

nurses who have stayed with us—we can't up their salaries. We can't offer them anything more. I think we need to look at that.

Mr. SMITH OF NEW JERSEY. I thank you for your testimony.

Ms. WALSH. Could I just make a few comments? You asked how sometimes patients at the Portland VA are getting worse, which I have seen.

With the staffing ratio at times when I was working on the floor as high as 11 patients to 1 nurse, there was no way that nurses frequently could manage that many patients. A lot of times when I worked on the floor I was working with one other staff person for a total of 18 hours of care that we could provide, and I would have 46 to 48 patient-hour needs to provide.

It still is going on. Patients frequently lie in their own stool and their own urine for well over an hour at a time, not because the nurse does not know that there is a problem there, but because she is not able to get to the bed to clean it.

I have seen one of my patients that I took care of who had some surgery done several months ago. He also had severe arthritis. He had a lot of arthritic pain. He was getting pretty much around-the-clock morphine.

I was not there when he went into the intensive care unit; however, he eventually got too much morphine on board. He had a respiratory arrest and wound up in the intensive care unit. The reason that happened is because nursing was not adequately assessing his pain. Why were we not taking care of and assessing his pain? We didn't have the time to do so.

Usually in any given 15-minute period on the floor the nurse is going to have anywhere from 5, 10, 15 interruptions. She is not able to get her work done.

Mr. MONTGOMERY. The time of the gentleman has expired.

Les? Go ahead.

Mr. AUCOIN. I appreciate this, Mr. Chairman.

Ms. Walsh works at the Portland VA Hospital—a hospital I have worked very hard to get established and built. It dismays me to find out that one whole ward cannot be operated because of the shortages that she has described today.

This 11 to 1 ratio of patients to nurses in Portland is, I think, significant. My understanding is that the ratio in neighboring facilities in the private sector is about 5 to 1.

Ms. WALSH. It is 4 and 5 to 1. Now, things are a little better today at the Portland VA than they were earlier this summer.

Mr. AUCOIN. That 11 to 1 is also somewhat misleading, isn't it, Ms. Walsh, because if one of those 11 patients that you are dealing with suddenly develop some special problem then a longer period—you're not apportioning the amount of time you have on your shift equally among patients.

Ms. WALSH. True.

Mr. AUCOIN. If someone is really hurting that means that everybody else is going to be finding himself with even less attention from the nurse. Is that not the case?

Ms. WALSH. That's true. We have patients that don't report pain. We have patients with anginas that do not report their heart pain.

Mr. AUCOIN. And you have had the medical results that you have just described.

Ms. WALSH. That's correct.

Mr. AUCOIN. People have been in trouble because of the lack of attention.

Ms. WALSH. That's correct. We wind up sometimes giving medications and we are not able to adequately assess the affect of the medicine that we give them.

Mr. AUCOIN. I think, Mr. Chairman, that's just a dismal way to treat veterans who come to these facilities for care.

I'm just reading the statement by the VA at last year's appropriations hearing in which it was stated, "Despite the overall austerity of the federal budget, we have the medical request"—that's the budget request they are proposing to the Congress—"that allows the VA to continue providing quality health care to eligible veterans and beneficiaries." And it goes on to justify the quality care.

There is not one mention—this is a statement of Mr. John Gronvall, who I understand is going to be testifying in the next panel—nowhere in this statement is there any reference to the potential problems that we now come together to discuss today. What is your reaction to that statement as a nurse?

Ms. WALSH. As a nurse, I would have to say that quality of care is a misnomer. We have lack of quality of care.

Mr. AUCOIN. Thank you.

Mr. Chairman, I have other questions for this person who is my constituent, but I would like to submit them for the record.

[Not received at time of publication.]

Mr. MONTGOMERY. I want to commend this panel for being so open and just coming right out. It has really helped us a lot. Thank you for being so up front.

Mr. Solomon?

Mr. SOLOMON. Mr. Chairman, I'd just like to point out that with Ms. Hudec not only is she serving her country today as the chief of nursing services for Washington, D.C., but she is also a Vietnam veteran who served in a combat area as a nurse, and she is to be commended.

Ms. HUDEC. Thank you.

Mr. MONTGOMERY. She's much better looking than a lot of these old combat veterans I have seen around.

[Laughter.]

Mr. MONTGOMERY. Thank you very much. We appreciate you being here today. Thank you. You were excellent witnesses and I want the record to show that.

I would like to call General Turnage. We appreciate his patience. He is the administrator of veterans' affairs. Also we call Dr. John Gronvall, the chief medical director, and Mr. Conrad Hoffman, the director of Office of Budget and Finance for the VA.

I might say that we have other witnesses—distinguished Americans—Dr. Custis and Dr. Schafer and Ms. Gloria Hope. And then we have a panel of veterans' associations, and we appreciate their patience also.

General Turnage, I'd like to ask Mrs. Turnage to stand up. She is a good friend of ours, and she has been sitting back there very patiently.

[Applause.]

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Mr. MONTGOMERY. Thank you for being here. We always enjoy having you come to these hearings.

General Turnage, why don't you proceed.

STATEMENT OF HON. THOMAS TURNAGE, ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION; ACCOMPANIED BY JOHN GRONVALL, M.D., CHIEF MEDICAL DIRECTOR; AND GARY COLE, DIRECTOR, BUDGET SERVICE

Administrator TURNAGE. Thank you, Mr. Chairman.

Mr. Chairman, as you see me go through these pages with the speed that I do you will note how many changes I have made since these hearings started, and I do that in deference to your time and to get away from some of the repetition that we'll have.

Mr. MONTGOMERY. Thank you very much. And I want to thank you and your staff for being here and hearing this testimony. That's one reason we had it arranged like this—so you could tell it the way you want to.

Administrator TURNAGE. Thank you.

I'd like to take this opportunity to thank the members of this subcommittee—especially you, sir, and the ranking minority member, Congressman John Paul Hammerschmidt, and, of course, Congressman Gerry Solomon—for your continuing support of our nation's veterans and the VA employees who serve them.

At the outset I particulary appreciated the tone that you established for these hearings, and I found it to be quite objective, and I appreciate that.

With me today at the witness table are Dr. John Gronvall, Chief Medical Director, and Mr. Gary Cole, Director of Budget Service. I would request, because of all the changes that I have made in the last few minutes here, that the complete written statement be included in the record, if you please.

Mr. MONTGOMERY. Your prepared statement will be inserted immediately following your oral presentation.

Administrator TURNAGE. I am extremely proud of the chief medical director and the personnel of the Department of Medicine and Surgery overall for the excellence that they are achieving in our system.

I will trade over now to some of the comments that have been paramount in recent days. In recent days there has been considerable controversy created in the media and other circles regarding nurses and bed levels in the VA, and I guess it is appropriate following the three distinguished ladies that you had here.

I will discuss these issues briefly, and am prepared to provide additional details later as desired.

First, the nursing situation. In October of 1986, in response to what the VA, the Congress, and the health care industry foresaw as an impending national shortage in nurses, we initiated a survey of our health care professional staff. This survey was replicated in 1987 and provided valuable information upon which to develop agency plans to meet future staffing challenges.

The survey results determined that although there is a nationwide shortage of registered nurses of over 11 percent—and that

was stated as recent as a couple of weeks ago in an HHS report to the nation—the shortage in the VA is approximately 4.6 percent.

The chart that is displayed over here near the door shows the level of nurses within the VA health care system. As noted, the total number of nurses has remained fairly constant, with the number of registered nurses increasing, even in the face of the growing national shortage.

It is apparent that the overall level of nurse staffing within the VA compares very favorably with the situation found in the rest of the industry. Even so, we recognize that there are local and regional staff distribution anomalies that we need to address.

Understandably, the urban areas pose the greatest problem and are subject to the keenest competition for personnel available.

By the way, recently I found something that is very profound but is not unique in the system. In New York, as you know, we have a number of medical centers. In Manhattan we have a grievous shortage of critical care nurses and other nurses. If you go across the bay to Brooklyn, that medical center enjoys about a 97 percent average staffing of nurses and the Bronx as previously discussed has a shortage of nurses.

In Chicago we have four medical centers, and two of them have critical shortage of nurses; the others are doing quite well.

That is the difference in pattern and the anomaly that I suggested about the fact that across the board we have done well. In specific cases we have difficulty.

Now, the Chief Medical Director's sensitivity to that issue was validated by the visit of your committee staff to the 16 VA medical centers last spring, and the resulting report on nursing staff levels. These 16 sites—less than 10 percent of the medical centers in the system—were receiving over 44 percent of the special pay for nurses at the time of the visits.

We had identified the recruiting and retention difficulties at these stations and had taken corrective action. We will monitor this critical field on a continuing basis.

I should make a point here, because it has been noted by one of the nurse witnesses as well as Mr. AuCoin from Oregon, about the situation in Portland. I must tell you that what we have done here in an objective basis is make some notes where we have found contradictions between the statistics that we have and the information we have about conditions that exist in any specific place and allegations to the contrary. What we will do is go back and check that out to be sure. If, in fact, we have errors in our statistics we will change them; otherwise, we will find out why perceptions differ.

But in Portland, according to our data, at the end of June—2 months ago—we had an average daily census of patients of 371 people. We had 478 nurses there. That gave a percentage ratio of 0.78 patients per nurse. That doesn't track with 11 to 1.

Now, about beds——

Mr. AuCoin. Mr. Turnage, since you mentioned my name, when you do check would you please let me, as well as the committee, know what you discover.

(Subsequently, the Veterans' Administration furnished the following information:)

The cumulative average daily census for fiscal year 1988 (through August 31) at the Portland, Oregon, VA Medical Center was 372 for the Medical Center, 114 for the Nursing Home, and 29 for the Domiciliary. At present, the Portland VA Medical Center Nursing Service has an assigned FTEE of 421 RN's and 159 "all other" for a total FTEE of 580. The facility is currently 40 RN's below the assigned cumulative FTEE.

Ms. Eileen Walsh, R.N., of the Portland VA Medical Center, reported that the facility has a patient to nursing ratio of 11 to 1 and the Administrator stated that the ratio was 0.78 patients per nurse. Both individuals are correct depending upon how the ratio is calculated.

Using the ratio of patient census to Nursing FTEE, the Administrator is correct. Ms. Walsh, however, works on the evening shift where staffing would probably include three nurses plus one or two nursing assistants or LPN's for 33 patients and therefore her ratio would also be correct.

Administrator TURNAGE. Yes, sir, in the most objective way we can.

Mr. AUCOIN. And was a ward closed in the new hospital?

Administrator TURNAGE. Sir.

Mr. AUCOIN. Was a new ward closed in Portland?

Administrator TURNAGE. I can't tell you that, but I will find out and let you know.

(Subsequently, the Veterans' Administration furnished the following information:)

The new Portland VA Medical Center opened during the second quarter of fiscal year 1988. Within the available budget and considering a reasonable balance between staffing, workload, and "all other" account requirements, a 39 bed ward was deferred for activation.

Now, about beds: as you can see on this next chart, VA bed levels have declined since 1976, with the steepest decline between 1977 and 1981. That has been no surprise to anyone.

Since 1981 there has been a gradual decline as the demands for beds has decreased. Now, this overlay that we will put over the chart demonstrates the average daily census compared to the bed level over the same period of time. Clearly the number of veterans in our medical center beds has declined at a faster rate than the number of beds.

The bottom line, it seems to me, is that the data suggests that overall, even if we had twice the number of beds, we would have no increase in the number of veteran in-patients treated by the VA.

It is important to note that if one adds the number of beds available for service—which includes nursing bed capacities by your own definition—and the number of beds temporarily out of service because of renovation or construction activities, we still exceed the 90,000 number dictated by the Congress.

Now, as far as the current status of medical care funds is concerned, things are tight. And I say that unequivocally, and I have full realization of that fact.

I have sought and received repeated assurance that we will continue to deliver quality care to all entitled veterans this fiscal year without exceeding our appropriation. I have not attempted to minimize the challenges we fact, but neither have I resorted to hyperbole or emotion or anecdotes or negativism to solve the highly-complex management problems, and that's what some of it relates to.

My assurance that we will continue to deliver quality care to all Category A veterans this fiscal year without exceeding our appropriation is derived from visits to 64 medical centers, discussions

with patients, staff, and directors, observation of physical plant standards, and opinions of senior medical officials supported by definitive patient data.

As a matter of fact, this year we have $422 million more than last year. At the end of July, 10 months into fiscal year 1988, the medical care appropriation expenditure was under-planned by approximately $1 million against the planned expenditures of $8.4 billion. At the same point last year the medical care account was under-planned by approximately $75 million against planned expenditures of $7.9 billion.

We are running much closer to plan this year. We have obligated approximately $190.6 million toward the purchase of replacement and additional equipment as compared to $191.6 million last year, and we have obligated approximately $20 million more in lands and structures replacement or additions over fiscal year 1987.

We have some real challenges, but we are attempting to manage them in such a way that we can guarantee the future viability of the system. We do have problems in the equitable distribution of resources to individual medical centers, and to adjusting quickly to changing requirements in the field. The whole system, over a country as broad as ours with a dynamism that is reflected in the population—particularly the veterans' population and the movements to the Sun Belt and otherwise—requires that we are able to respond to these adjustments.

Last year we had 70,000 changes in medical center budgets from the time we started until the time we closed the fiscal year.

We are attempting to move resources from areas that are serving a declining number of veterans into areas of increasing demand. These shifts I am sure are perceived as budget cuts to those facilities that lose funds, and they have led to cries that VA funding was being reduced overall. In reality the shifts were simply an attempt to re-allocate resources to those areas of greatest need. That is one of John Gronvall's greatest challenges.

We face some real constraints on the efficient management of resources from certain provisions of the law, and here is a case where perhaps your committee can specifically be of assistance.

We have heard others talk today about some of the constraints that are put on because of inflexibilities that have been established by law. This might help.

For example, in fiscal year 1987 approximately $70 million lapsed in the medical care account due, in part, to the arbitrary floor on personnel services dollars included in the appropriations language. We have, as a matter of longstanding practice, contracted for certain health specialists when it was to the advantage of the agency or when hiring difficulties precluded hiring the required staff.

However, we do not receive either FTEE or dollar credit for these contract personnel under the current law, and we are required to expend funds to meet an arbitrary floor—194,140—on FTEE, even though we believe a portion of those funds could be better used elsewhere in the medical care system.

This fiscal year we spent approximately 2,254 FTEE and $138 million in that program.

Additionally, when the Congress mandates services and benefits without concurrent supporting appropriations we face real management challenges.

Passage of Public Law 100-322 that went into effect on July 1 was responsible for much of the recent churning in our system as DM&S had to re-allocate its resources to support these new mandates.

From the perspective of the agency I am convinced that this year, within available resources, we will continue to deliver quality medical care to all veterans whose care is mandated by Congress, and that it will be done with concern for the future viability of the entire system.

It is my deeply-held conviction that false impressions generated by unfounded assertions of inadequate quality of care or denial of care to entitled veterans can only inure to the disadvantage of veterans in the long term, and also to the disadvantage of the Veterans' Administration.

With your approval, I would ask Dr. Gronvall now to present his assessment.

[The prepared statement of Administrator Turnage appears on p. 128.]

Mr. MONTGOMERY. This is a good time for us to go and vote, General Turnage.

I'd like the members to go over, if they can, and vote and come back quickly. We will start the hearing and get Dr. Gronvall, and we will push on and finish the hearing tonight. We are now in recess for 10 minutes.

[Recess.]

Mr. MONTGOMERY. This subcommittee will come back to order. The members will be in.

Dr. Gronvall, the Chair will recognize you as chief of the medical services.

Administrator TURNAGE. Mr. Chairman, I have such confidence in Dr. Gronvall that I left him a note and told him I'd see him later, but he insisted I stay.

Dr. GRONVALL. Thank you very much, Mr. Chairman. It is a pleasure for us to be here.

My written statement develops a context for looking at the present status of the Department of Medicine and Surgery, and I would ask that that be included in the hearing record.

Mr. MONTGOMERY. Your prepared statement will be inserted immediately following your oral presentation.

Dr. GRONVALL. Let me, in a few minutes, then, try to summarize from that statement, first to set a context for the forces and factors over the recent years that have lead to the present situation.

The past decade, not only in the VA but throughout all of American health care, clearly has been a decade of cost consciousness. I think that anyone who reviews the record would come to the conclusion that the accomplishments of the Department of Medicine and Surgery during that decade in expanding the amount of care we have delivered and enhancing productivity should be viewed as a record of outstanding success.

To be more specific, since 1979 the VA has increased the number of veterans we have treated in our hospitals. We have increased

the number of veterans in our nursing homes, domiciliaries, and in our contract care. And, in addition, during this time we have remarkably expanded the amount of out-patient care that we deliver.

During this decade, as has already been pointed out and as is pointed out in my statement, our appropriations support, when it is viewed on an inflation-adjusted basis, has been essentially level. Fortunately, we have been able to compare the VA's record with the record of the entire community hospital or private sector health system. This comes from data from more than 5,600 community hospitals.

When the same decade is compared for private sector medicine, in recent years there has been an actual decline in the number of hospital admissions, there has been an increase in out-patient care, but the most specific difference is noted when the aggregate cost of operating the private sector is reviewed, because it is apparent that there has been approximately a 20 percent real increase in the operating cost of the private sector.

Parenthetically, there have been many comments today about the financial agonies of the private sector. I think that further establishes the context of the VA health care system where, on the basis of level operating support, we have expanded our health care delivery compared to the private sector that has had a declining number of patients treated in hospitals and has still had something like 20 percent real growth in operating support.

We in the Department of Medicine and Surgery believe that this emphasis on productivity in the past decade has been sound public policy as an effort to get the biggest bang for the buck that is available to us in the department, and we believe that this is an enviable record of improving productivity.

A major focus in this hearing has been on hospital beds and the number of beds we are operating. Mr. Chairman, the policy of the department is to operate and maintain a sufficient number of beds to care for eligible veterans who apply for admission and are medically in need of being admitted.

The statutory level of hospital and nursing home beds of 90,000 was established in 1981. Since that time, patterns of patient care have remarkably changed, and length of stay has significantly decreased, and we can now serve the same number of patients in fewer beds.

In fact, our occupancy in the most recent full year—fiscal year 1987—was some 71 percent. To continue that trend into this current year we have followed very closely our data on the number of veterans that we have treated in our hospitals, and in spite of the fact that we have had beds closed, the fact is that we have treated 4.4 percent more veterans in our hospitals this year than had been projected in our original 1988 operating plan.

The budget summit agreement, or bipartisan budget agreement, has been referred to many times in the testimony, and from our standpoint within the department, the impact of that agreement on our operation during this current year was very clear. We were given an explicit mandate that the appropriation we received was to be the total amount of funds that we had available to operate throughout 1988, and that mandate which came from the agreement between the Congress and the Executive Branch also explicit-

ly mandated that no consideration would be given to seeking supplemental support during 1988.

On that basis, then, once we received our appropriation we made a set of budget adjustments within the department early in the second quarter of the fiscal year. We gave our medical center directors their clear marching orders that that was the amount of money that they were going to have available this year to operate through the remainder of this year. And it was on that basis that I have repeatedly assured the Administrator that we would continue our operation throughout the year without violating the Anti-Deficiency Act and without turning away any Category A veteran needing care.

We accomplished this on the basis of internal re-allocations, as has been dramatically described today. But the result of that practice is, I think, agreement by everyone who has reviewed the system that we have essentially exhausted our ability for further internal re-allocations.

Our financial situation this year was further complicated by the passage of Public Law 100-322. That law mandated that we implement a number of provisions in July that further stressed our resources, and required a further internal re-allocation.

We, of course, were then very fortunate to subsequently receive supplemental appropriation support for that impact, and we have allocated those supplemental funds back to the sources from which we had made the earlier internal re-allocation.

One other comment I think is important: as a specific problem this year, again, there has been much testimony here about the national shortage of nurses and other critical health professionals.

Our detailed statement describes a number of the activities we have carried out and programs we have put in place to attempt to retain our staff and recruit additional staff. We do have significant problems in specific geographic areas, but on an aggregate basis throughout the system, to take nurses as a specific example, as of this moment we are within 2 percent of the highest level of nursing staff that has ever been employed in the VA.

So we have had a decline in the current year, but on a proportionate basis it has been very small.

The cost of accomplishing that, however, has been, again, a significant internal re-allocation because the special pay agreements that we now have in force add up to somewhat over $100 million. All of that money has been accomplished through internal re-allocation. I am pleased that the 1989 appropriation recently passed recognized that need by allocating an additional $45 million for special salary rates.

In conclusion, Mr. Chairman, it is clear from all of the testimony that the operating margin in the department is narrow. Very difficult resource decisions have had to be made. I would repeat my regular assurance to you that the goal of providing quality care remains our clear objective, and we look forward to the opportunity that this hearing provides to respond to questions and further clarify the current state of the department.

Thank you, sir.

[The prepared statement of Dr. Gronvall appears on p. 149.]

Mr. MONTGOMERY. Thank you, Dr. Gronvall. Thank you, also, General Turnage.

Certainly your testimony is rather rosy, and it is almost in total disagreement with the witnesses we have had, and I imagine the witnesses that will follow you. I am fond of both of you, and we get along well together, and we talk through our problems. But you have got some problems out there, and we are here to help you. I just wish you'd tell us about them and we'd try to work it out. But it is not that good out there.

General Turnage, you've said publicly, and made a statement recently, that you don't know of one veteran that has been turned away. I followed your statement today and you didn't say that.

For the record I have a list here—and it is a good list. I know some of these people, and they have been turned away. It might be an appointment far in the future, or it might be shortage of surgical beds, but they have been turned out.

(Subsequently, the Veterans' Administration furnished the following information:)

The Department of Medicine and Surgery has reviewed each case and has provided comments to the Committee on each.

Mr. MONTGOMERY. Your own Directors have really, in effect, disagreed with what you have said there. They put it in writing and we have it in the report here that there is a shortage of beds because of funding and because of nurses, and we want to do what we can to get this mess straightened out.

I have been fortunate to be chairman of this committee about 8 years now, and we are having more complaints from veterans about health care than we have had in the years that I have had the privilege of chairing this committee.

So something is wrong. We're not over here to rake you across the coals. We would like for you to tell us if you need more money, if OMB will not let you get the money, if you've got nurse shortages. You do this. We try to do this in the Congress, and we can do a better job for you. So that's where I'm coming from.

Administrator TURNAGE. Would you let me make another run at it then, Mr. Chairman?

Mr. MONTGOMERY. General Turnage?

Administrator TURNAGE. I think that I stated here today that things are tight. We reiterate that now, and I have no compunction about suggesting that to you. And even in that context, however, they are tightest for those people of the 172 entities that have to have allocations of funds that receive less funds than they did the year before. But that is not the pattern across the board, Mr. Chairman.

And the fact is: if you take it on balance, while we are tight now and we are having difficulty, I am not going to go around the country telling people how tough things are and being negative because I know something about leadership after 39½ years in the system, and if I start singing the blues about things that are not true and listen to the doom-sayers, then we also have a morale problem in our system.

Now, I don't know who selected, for example, the witnesses that came before this body today, but it just happened that a number of

them reflected only the shortages and the sad part of it. I didn't see any that said they didn't have a nursing problem at their hospital—and most of them don't, Mr. Chairman.

Now, I've asked all along if someone found an individual who wasn't being treated to let me know and we would take care of it. I have received no such list, sir. I welcome you to send it to me.

Mr. MONTGOMERY. I have it right here, General Turnage. I was hoping you were going to ask for it. I have been waiting on you to—I've got a good list here, and a couple of them are my cousins, and they need some help.

[Laughter.]

Administrator TURNAGE. Let me suggest this: I am disenchanted, Mr. Chairman, that you would wait to give it to me here under these auspices. If I had known they had problems earlier and you had given me the names we would have taken care of it.

Mr. MONTGOMERY. That's a good point. I will send you express mail or however you want it. I would be very glad to get you the list, and I'm getting the lists, and they're coming in and compiling them.

You've got some problems out there.

Administrator TURNAGE. Please allow me to develop one other point which was made here earlier. When we found out that we were going to have the additional entitlement embodied in Public Law 100-322, we went for a supplemental then. Ultimately what we got was $31.7 million, which was referred to by the Chief Medical Director a few moments ago, and that has been most helpful.

We also, last week, submitted a supplement for what we know will be next year's deficiency. And, unfortunately, our appropriation for 1989 was in before Public Law 100-322 was passed, one; secondly, it has been passed, and a matter of record now, and the supplement we send in—based on your system, not ours—cannot be acted on by law until the President submits his budget in January.

I, like Mr. Solomon, would suggest that here is a case where this body can help us overcome that deficiency by taking any other action you think is appropriate—to not wait until next year, but do it now so that Dr. Gronvall can go into the next fiscal year knowing what he's got to work with. That would be critical to us.

Mr. MONTGOMERY. That's fine. That's what we want to find out. That's good.

My time is up, but you hadn't made enough requests, General Turnage. You can get behind the budget and say this and that, but over the years you have not made enough requests. I know personally that you and Dr. Gronvall have gone to OMB and said you need more money, and they have turned you down. IS that correct.

Administrator TURNAGE. There have been times we didn't get what we wanted, of course.

Mr. MONTGOMERY. What kind of answer is that?

Administrator TURNAGE. Well, the answer to that is yes, sir.

Mr. MONTGOMERY. Okay.

Administrator TURNAGE. There have been times when we asked for money but we didn't get it.

Mr. MONTGOMERY. I'd like an answer of "yes, sir" or "no, sir," and that's what you did.

My time is up.

Gerry?

Administrator TURNAGE. I'm rather glad.

Mr. MONTGOMERY. You did all right.

Mr. SOLOMON. Sonny, I'll yield you some time if you want.

Mr. MONTGOMERY. Go ahead.

Mr. SOLOMON. Mr. Chairman, I appreciate the witnesses coming in and General Turnage and Dr. Gronvall. I have deep respect for them.

But I am really concerned with how we are going to work out this problem. We've all talked about it. I think Joe Kennedy and all of us here and Charlie Stenholm—you know, we are bound by the budget summit agreement, and we all are guilty—or we can take credit for, whichever way you want to look at it—of being a part of that, because we agreed to it—we, the Congress—and the President of the United States, and everybody else. We are bound by Gramm-Rudman-Hollings and sequestration which we all have to worry about. If you are worried about housing, and if we come up with a supplemental on this Veterans' Administration budget that's going to hurt someplace else, and we have got to take all of those things into consideration.

While we are at it, I want you to give some thought to this subject of third-party reimbursement that I brought up before because, you know, after that got off to a very slow start, as I understand it now that third-party re-reimbursement is beginning to finally bring in substantial revenues.

Now, unfortunately it didn't do what I wanted it to do in the first place because I wanted those substantial revenues from third party reimbursement to come in to the veterans budget so that we could use those funds. One, we need them—especially now that we are bound by the budget summit agreement and by Gramm-Rudman-Hollings; but, secondly, because those funds could be used to make up the difference of what we are bound by here.

Now, I don't think that that money ought to go in the treasury. I think we ought to be able to use that, and maybe this committee ought to be thinking about how we might be able to change that around to help us while we are bound by this budget agreement.

Now, I mentioned in discussion with the four hospital administrators that were here that the average shortfall is about $4 million per hospital. Now, some of them were $2.8 million with Mr. Ayres; some of them were $5 million with Boston. But the average that I've been able to look through here comes out to about $4 million, forgetting about the out-patient clinics. We have got a $600 million or $700 million shortfall.

I discussed what you just discussed, General, in the fact that you can't even come in here and ask for a supplemental until after the budget is submitted in January, and that leaves us one-third of a year short already, and, you know, when you consider that if you are short $2 million or $3 million and you have to make that up over the course of a year, that means so many jobs that you have to eliminate.

But is you have to take that same number of dollars and eliminate those jobs over two-thirds of a year, then you're talking about more jobs.

So we have got a very, very serious problem here.

I don't know too much, Sonny, about this business of deficiency apportionments, but because of the legislation that we passed—this 100-322—and maybe you can elaborate on what that cost is fiscally. In other words, for 1989 this kind of legislation qualify you or us to ask for a deficiency apportionment in order for you people to go ahead and spend according to what we have mandated on you?

Administrator TURNAGE. I'm sorry. I can't answer that question, sir.

Do you know, Gary?

Mr. COLE. One thing that qualifies, of course, is the pay raise.

Mr. SOLOMON. Is what?

Mr. COLE. The pay raise that is coming in January. That is deficiency funded. But I'm not sure this qualifies as deficiency funding.

Mr. SOLOMON. Well, we mandated by law the beneficiary travel. We mandated by law the per diem rates for state nursing homes. I'm just trying to find out.

You know, we've got to deal with this thing. We have got to deal with it now. We're going out of session here in 3 weeks. We won't be back here until January 25th, and by the time we get around to it you have got real problems.

Now, what are we going to do about it? How are we going to deal with it?

Administrator TURNAGE. Well, the first thing we'll do is get the answer to that question, and I don't know the answer. I don't know if anyone here does have the answer.

But what I suggested to you earlier when we talked privately about this, I'm wiling to go to the White House; I'm willing to come to this committee; I'm willing to go to Appropriations or anyone else in order to help take care of the deficiency that we project for next year. And in fairness to the veteran and to the management requirements imposed on Dr. Gronvall he needs to know by October 1 what kind of allocation of resources he can make to these hospitals all over the country, and right now it is going to be tough.

Mr. SOLOMON. Well, General, I want to thank you for that, because that's important that you are willing to go to the White House and talk about this particular problem. I think maybe Sonny and I ought to go with you.

Administrator TURNAGE. Well, we've already made the initial entreaties—as a matter of fact, on Tuesday—and then I went to Louisville and came back last night, and we will do so again at an early time because I recognize the criticality of your schedule here.

Mr. SOLOMON. Mr. Chairman, like you I have got a lot of other questions. I'm going to be submitting them to you, General. But I yield back the balance of my time right now.

(Subsequently, the Veterans' Administration furnished the following information:)

The following conditions qualify for deficiency apportionment:

a. laws have been enacted subsequent to the transmittal to the Congress of the budget request that require expenditure beyond administrative control;

b. emergencies arise involving (1) the safety of human life, (2) the protection of property, or (3) the immediate welfare of individuals in cases where an appropriation that would allow the United States to pay, or contribute to, amounts required to be paid to individuals in specific amounts fixed by law or under formulas prescribed by law, is insufficient; or

c. supplemental appropriations are required to permit payment of such pay increases as may be granted those employees (commonly known as wage board employees) whose compensation is fixed and adjusted from time to time in accordance with prevailing wage rates.

The Agency will be in discussion with the Office of Management and Budget to determine if the above conditions for deficiency funding are applicable.

Mr. SOLOMON. I really do appreciate your sincerity in offering to do that because I think we've got to do that, and we've got to do it within the next three or 4 weeks to determine how we are going to solve the problem for later on. Otherwise, if we are one-third of the way down the year we are never going to recover. We won't be able to sell the Congress on what we need to do to maintain these current services.

I yield back the balance of my time.

Mr. MONTGOMERY. Thank you.

General Turnage, before yielding to Roy Rowland let me put int he record one statement that you made that I will have to disagree with. You said the witnesses that we had here today were probably witnesses who had shortages of nurses, and that most of the hospitals didn't have that shortage. Wasn't that——

Administrator TURNAGE. That was my statement, sir.

Mr. MONTGOMERY. Well, this report shows that 129 hospitals out of the 172 reported beds out of service for medical staff shortage. So 129 out of 172 is a large number. It is not a few.

Administrator TURNAGE. Mr. Chairman, in all deference I must suggest to you that I don't endorse everything I find in that report. There is one hospital there, for example—it happens to be Boston—where the individual says he needs 602 additional nurses. That would make it something on the order of two and a half nurses per patient.

And so there are other things that I consider to be inaccuracies in that. Some of it is the wish list. And so I don't agree with all of that.

I must suggest to you that I have been to 64 of these places myself, and I have some kind of insight into what they're doing and how well they are doing it. Some of them are grievously hurting, but across the board there are some places in the hinterland where you can't drive nurses away because they like it.

So if you talk about numbers it becomes subjective. I'm just suggesting to you that we do have a problem. We're trying to address it, but I don't agree with all that I find in that report.

Mr. MONTGOMERY. I'm sure that's correct, but I think what you're saying is that it is a few. It is much more than just a few out there, General Turnage.

Administrator TURNAGE. Yes, sir. I'll agree. Whatever a few means. I will agree.

Mr. MONTGOMERY. That's 129.

Roy Rowland?

Administrator TURNAGE. I didn't agree with that figure.

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman.

Thank you for being here and for your testimony today and for your willingness to try to address this problem.

I think we all need to be working together and not in an adversarial role with one another in trying to resolve the problem that there is here. You agree that there is a problem.

Everywhere that I go I promote the VA as being the best health care delivery system in the world, and I really believe that. I believe that there is quality care there, and I believe that we still have quality care.

But let me——

Administrator TURNAGE. Sir, would you allow me? If I have said anything, or by manner or inference or otherwise given you any kind of impression of adversity or an adversarial relationship I apologize. I hope we are all working together.

Dr. ROWLAND OF GEORGIA. Well, I certainly hope so, too. And, no, you haven't done anything here to indicate to me that there is an adversarial role that exists here, although I do wonder why the requests have not been made for funding for DM&S to adequately address the problems that we are addressing here today.

But let me go on to draw an analogy. While things do seem to be doing fairly well now, even though these problems do exist that we have heard about today, we seem to be doing extremely well in our country now from the standpoint of the economy. Our budget deficit problem is not something that seems to be affecting the lives of individuals especially or immediately. And I think the reason for that is the fact that our deficit is being financed, to a large extent, by foreign capital that is coming in here. We really haven't felt the full impact of what this budget deficit problem is going to mean to us in the next year or so. All economists are predicting that we are going to have a recession, and I think it is, in large part, due to that.

Now, in the VA we are doing very well right now because directors have been robbing accounts in order to meet specific needs in other accounts.

In other words, I think that we're living in sort of a dream world in the VA right now, just as we are living in this country in general insofar as our economy is concerned, and that in the not-too-distant future we are going to have to address this problem. We're going to really have it come down on us.

We heard this testimony here today from the directors of hospitals, we heard it from nursing personnel, also, that the problem exists. And if we don't address this problem, then we're going to find ourselves, if you will, in a recession in the VA health care delivery system, just as we are probably going to find ourselves in a recession in our economy.

So I wanted to draw that analogy there because I think it is a valid one and I'd like to hear your comments on that.

Dr. Gronvall, in reading your statement you said at some point there were limits to what the VA could do. Have we reached that point? Have we reached a point now that we can't do any more than what we are doing? Should we say that this is the status quo and we're going to hold this right where it is?

Dr. GRONVALL. I wouldn't agree with the tail end part of your comment, but it is my absolutely firm judgment that the department now has no significant capacity for any further internal re-allocation.

Said a different way, any new responsibility that we are asked to carry out, any new expansion of work load or whatever, cannot be accomplished by internal re-allocation.

So it is my judgment that we have exhausted that internal flexibility.

Dr. ROWLAND OF GEORGIA. Well, do you think that we need to consider expanding or growing to meet the aging veterans' population that we all hear is coming?

Dr. GRONVALL. All of our projections predict for at least the next decade a growing level of demand on the VA health care system based on the aging of the World War II and Korea era veterans and the well-established fact that older individuals—veterans and all citizens—require a higher level of medical care.

Dr. ROWLAND OF GEORGIA. We have heard today from the directors of the hospitals that the principle problem lies in OMB. Do you concur in that feeling, or is there some other problem?

Dr. GRONVALL. I surely concur that the final—in my judgment—the final judgment each year on the size of the President's budget request in my personal judgment has not been an adequate request to meet the needs of an expanding medical care demand on the VA. And I think each year when we have testified in support of the President's budget through the established hearing processes, each year it has been pointed out that the President's budget request proposed a reduction in staffing in the Department of Medicine and Surgery, and I have been asked what the impact of that would be. I have testified each year that if that is the appropriation we actually get we would, of course, have no choice but to reduce our staff and reduce the size of our delivery system in order to preserve the quality of care that we would delivery.

Dr. ROWLAND OF GEORGIA. So you could really use more money than OMB has been letting you have, then.

My time is up, but let me just make this comment, Mr. Chairman, that I believe that this is really one of the reasons that we need to have a cabinet-level position for the Veterans' Administration. I think the administrator needs to move to a cabinet-level position so that he can be at the table so that he can be in a position to bargain better for the budget that comes to the Veterans' Administration.

Thank you very much.

Mr. MONTGOMERY. Thank you. I certainly agree with you.

Claude Harris?

Mr. HARRIS. Thank you, Mr. Chairman. I also want to agree with Dr. Rowland. I think he couldn't have said it any better.

General, one thing that bothers me—and I mentioned it earlier and you, of course, heard it—is that in trying to make some kind of judgment on the budget, and I realize that the recent law that we passed is going to make some additional strains on you, but evidently a lot of the things we have heard have been an accumulation over a period of time, and that your people, to find resources, were spending money they had for equipment and different things just for staffing and what not.

It looks to me like there has got to be a better way of communicating the problem to the people that are trying to make some decisions about the funding, because we do have scarce dollars, as you know. But if you have got some idea what you're talking about, then you can kind of help compete with the others for the dollars that are there.

I know I had a round of community hearings on this last recess, and I guess I had more complaints this time about the VA, and people with 40 percent disability who had heart surgery that had no follow-ups after such and such a date, and just really hadn't had that many up to that point. So there is a problem out there, and you're right that we have got to work together.

Administrator TURNAGE. I don't think the problem is uniform in all segments of the operation. Let me explain, sir.

For example, last year—and I think most of you have heard me say this here—I try to instill the positive side of the operation as it goes. Last year, fiscal year 1987, we spent $770 million for renovation, refurbishing, and construction, which was the highest amount of real dollars that has been spent since 1945.

Right today, right now, there is $1.6 billion in progress for construction. But someone else said here today that if you don't have staffs to man those——

Mr. HARRIS. I said it.

Administrator TURNAGE (Continuing). Then you have a two-edged sword here. It doesn't work to your advantage overall.

Mr. HARRIS. I agree.

Administrator TURNAGE. So I'm suggesting that on one hand—on the physical plant, on the construction progress, the projections for the future—frankly it looks quite good. And if somebody says—and I heard Mr. Kennedy comment earlier about the situation with the out-patient clinic in Boston, and it is an atrocity. It is a GSA building, and we are trying now to follow the additional encouragement of the entire Congressional staff out of Massachusetts to get them out of there somewhere else.

But if you look at the whole instead of one or two or some anecdotal type operations, here we spent $9 million to find out from outside engineering sources how well our operation is across the country, and they found out that of all of our medical centers and so forth they assess it—an outside, independent agency—that we are in good shape.

Now, what worries me—and Dr. Gronvall will probably elaborate—some aspects of the equipment thing, which has been backlogged over a long period of time, does worry me.

We have some of the medical technology in our system that really is not available in the private sector. But, on the other hand, we don't have enough of it and, in effect, it is spotty in that sense.

Perhaps you would like to elaborate, John.

Dr. GRONVALL. Yes. I would be pleased to elaborate on that, and there have been calls here for straight talk, and in my perspective, when you look at the past decade and the way that the committee, itself, and our testimony has portrayed, during that time, by comparison to the rest of the medical community, we have accomplished a work load increase with essentially level funding compared to, in the private sector, a slight work load decline with significant expanded funding.

What that translates to in the VA, I believe, is a lower level of replacement of obsolete equipment, acquisition of new, high-technology equipment, changes in staffing, keeping up with medical practice because the standard of quality of medical practice in this country, of course, is set not in the VA but in the private sector. So

whatever happens in the private sector establishes the benchmark for how our clinicians and our nurses and our health delivery staff within the VA feel about the adequacy of the VA operation.

That is a judgment that is made within the hospital that is wholly independent of any statistical analysis of how the VA budget compares to other parts of the federal budget, or the kind of analysis that go on in a Washington central office.

So in that context I believe that there is clear evidence that on a comparative basis, while we are proud of the record of expanded productivity, it has lead us to the point where we now face a problem, have exhausted our internal flexibility, and where the staff working in our hospitals see a significant comparative gap with the best of care at least that is going on in the private sector in teaching hospitals and university hospitals.

Again, the status of the hospitals in the private sector is not uniform in the same way that it is not uniform within the VA. The problems are not uniformly spread across the country. There has been testimony here of the agony in private sector hospitals. The most recent American Hospital Association report that I have seen documents 79 private sector hospitals that have closed during this past year.

So there are hospitals in the private sector that clearly are much worse off financially than any VA hospital. They tend, as Mr. Stenholm has already commented, to be small hospitals and particularly rural hospitals, and there are a series of specific problems that relate to those hospitals.

But, again, I think the standard of high quality care that is really established in this country, and toward which we always want to be measured, and toward which we always want to set our sights, is the best of care that is delivered in the best of the community hospitals. Those tend to be the larger hospitals—often teaching hospitals or university hospitals.

I believe that a decade of what has been pointed out here—continually expanding entitlement or eligibility for care which has not been matched by follow-through appropriation—has accumulated that kind of equipment and technology deficit when the VA is compared to the best of medicine in the private sector.

So in that context I think there is a serious problem.

If someone asked if I could put an explicit number on that, the answer is no. I believe that might be done. It would involve a lot of judgments. And clearly in the process that is used each year for developing the formal President's budget request which rolls from year to year and is based on a large number of highly-technical analysis, staffing projections, etcetera, those kinds of aggregate factors of what is happening to the support system in the private sector don't find their way into the budget. But they accumulate over the course of a year, and over the course of a decade, and lead to the kind of problem that we're describing and hearing about here today.

Administrator TURNAGE. Sir, may I please add one more thing? I think it is important in this instance. There are other ways that we are making headway and progress where we are not simply by ourselves, and part of it is with the assistance of the chairman. We are now involved in many sharing agreements with Department of De-

fense medical facilities, to include one, for example, in Albuquerque. Recently when I went there to this new edifice it had "U.S. Air Force" on one side and said "VA" on the other. We share expenses, we share staff, we share modern technology, and so forth, at a level that we couldn't individually afford, but jointly we can.

We have 300 of those agreements now, and we are continuing to work on them.

So in those directions progress is being made. And, as a result, that reflects a sort of productivity.

Mr. HARRIS. Well, I appreciate that.

Mr. MONTGOMERY. We started that program, General Turnage, of combining the Armed Services and Veterans' Administration, and it——

Mr. HARRIS. Let me say one other thing. It looks to me like in trying to make decisions—I know, or at least I thought, that we were at least providing level funding for this next fiscal year. It turns out that evidently we're not because we've put everything on credit by spending our equipment accounts, and we have got shortages. Maybe somebody needs to come in and say we need equipment and we need nurses and we need doctors.

Thank you for the time.

Mr. MONTGOMERY. Okay.

Joe Kennedy?

I might say after Joe, so that you know in what order I've got it, that Chris Smith and Lane Evans and then John Rowland—the way you came in is what we have tried to do.

Joe?

Mr. KENNEDY. Thank you, Mr. Chairman.

General Turnage, the fact is that you were kind enough to acknowledge that the out-patient clinic in Boston is in—I think your word was "atrocious" shape. I have pieces of information here that could go through exactly what the situation is in several medical centers, which reflects on the rest of the system. Therefore it is an irrelevant point in terms of dealing with the overall situation that the veterans are up against.

Secondly, so many of the witnesses today seem to be at odds with the kind of testimony that you're providing. Nobody here wants to be disparaging toward the Veterans' Administration and the system that's in place, but, my goodness, I also don't think that we want to be supportive of a system which simply says that because a certain amount of money has been allocated, then that's the only amount of money that's going to be provided regardless of need. If we continued on that logic, then we're never going to deal with putting the dollars where the need is.

Therefore I think it becomes incumbent on you and on the Congress to have a relationship where you can tell us in all honesty what the need is. I don't feel that is really coming across. I don't feel that in these hearings that we've had together there is a really open notion as to what you are hearing from people from all across the country today—and they weren't just specific people who were selected to give disparaging testimony. I think if you look at the quotes you had in the paper disparaging the staff of this committee, in the Washington Post the other day, you're going to find that

that is what begins to create some friction between the committee and the Administration.

Specifically, I'd like to just go through some of the facts that I've learned on this committee that reveal that your final allowance for the fiscal year 1989 medical budget was $10.81 billion and 409,000 full-time equivalent positions. I understand that OMB further cut the budget to $10.35 billion and 192,358 FTEE's, and sent it over to the Congress. Your cuts from Dr. Gronvall's budget equal $658 million and 4,221 staff positions. The grand total reduction of Dr. Gronvall's budget, including OMB's reduction, is $887 million and 6,272 staff.

These reductions are from the budget of the doctor who is charged with running the largest medical care system in the United States. Let me read some of the things that got cut or reduced from Dr. Gronvall's request.

(1) Traumatic brain injury service;
(2) Spinal cord injury treatment;
(3) Outpatient clinics;
(4) Cardiac CT centers;
(5) A blind computer unit;
(6) CAT scanners;
(7) Bone marrow transplant programs; and
(8) PTSD treatment programs.

It seems curious that these cuts approximate the $819 million shortfall identified in the recent Chief Medical Director's Task Force report on the fiscal year 1989 budget. My questions are, with all the problems that the investigations and, as you say, the "anecdotal" reports, have highlighted, why aren't you coming to the Congress, telling us that the veterans are getting the care they need? It seems you should be verifying these deficiencies and letting the Congress carry the weight that comes from requesting more money. Let me just read you a couple more facts.

In fiscal year 1988 the VA requested $9.967 billion for medical care. The appropriations for VA medical care, taking into consideration the budget summit, gave the VA $10.94 billion—Congress therefore gave you $127 million more than you requested, yet you lay the responsibility for the funding problems on the budget summit agreement between the White House and the Congress.

In fiscal year 1989 the VA requested $10.295 billion and the Congress appropriated $10.568 billion, a difference of $273 million. Again the Congress met and then exceeded your request.

The point to be made here is that the Congress recognizes that veterans' health care is a high priority. We can only act when we have the information about the veterans' needs, and if the Veterans' Administration is not telling us about funds being diverted from maintenance and equipment accounts to pay for health care personnel while medical facilities are deteriorating, then how are we supposed to do our jobs?

It seems to me that the fundamental issue that is before us is, what reason do you have as Administrator of the Veterans' Administration for requesting large cuts in your own doctor's requests? Why did you do that? Why don't you just come to us and tell us that this is what the doctor needs?

Administrator TURNAGE. I don't think you want me to address that here in two or three bland statements and expect to meet all the figures that you pointed out there, Mr. Kennedy, over about the last 5 minutes. If you want me to do that for the record, I'd be glad to provide you a detailed reply.

But let me suggest that there is nothing sacrosanct about that $819 million budget shortfall. That was supposed to have been an internal document that Dr. Gronvall was working with with his staff to come up with some options that would be available to him so that he could make some decisions and judgments and recommendations. As a result—typically, like everything else—it got here plus everywhere else, and it has been published all over.

Now, I would hope that you would want to support knocking off that kind of routine in the future——

Mr. KENNEDY. Not really——

Administrator TURNAGE.—where he would have some management flexibility.

Mr. KENNEDY. To be honest with you, General, I don't have any desire to do that whatsoever.

Administrator TURNAGE. I would expect that you wouldn't.

Mr. KENNEDY. The point I'm trying to make is that if Dr. Gronvall feels that there is $868 million—whatever the number is—worth of additional benefits that are needed in order to meet the veterans' medical needs, then it seems to me that you should just tell us that. It shouldn't be some circuitous route. We shouldn't have to get the leaked report. We ought to be able to hear that directly from you, and you ought not consider us to be antagonists. Sonny Montgomery is the chairman of this committee; he works very well Gerry Solomon and with Paul Hammerschmidt. Why can't you expect them, as the Chairman suggested, to go to the White House with you and to really ask for the kind of help that is needed? I can't believe that Ronald Reagan is going to tell the veterans of this country that he's not going to help them. Let's talk about what is wrong with the system here, where you are unwilling to tell us what your needs are. I don't care if they're anecdotal. If there are serious problems in Boston, it's my business to know about it, so why can't you tell me that there are problems? Why don't I hear about them? Why aren't you calling me and saying, "Joe, we've got some serious problems," instead of me calling you and telling you about the serious problems that exist in Boston or elsewhere around the country?

Administrator TURNAGE. I recall very vividly that this was precisely the line that you used before when we had the previous hearing here, and I thought I gave you——

Mr. KENNEDY. Nothing has changed.

Administrator TURNAGE (Continuing). A reasoned response to it. As a matter of fact, there are no secrets, from our perception. I just got through suggesting that we have problems and I suggested that we would go to the White House and that we would do whatever is necessary in order to get what we need.

But let me suggest something else. I want to be sure it's in the right perspective, Mr. Kennedy. I don't expect, going back to what Mr. Harris said earlier, that we'll ever get what we want. My big

objective is to get what we need to do our job right, and that's what we're after.

Mr. KENNEDY. General, listen. If you come into the relationship assuming that you can't ask for what you need——

Administrator TURNAGE. I said my objective is to get what we need.

Mr. KENNEDY. I hope that what you need is what you want.

Administrator TURNAGE. I beg your pardon?

Mr. KENNEDY. I hope that what you need is what you want.

Administrator TURNAGE. Well, I think there is a difference. There is a difference between gold-plating and——

Mr. KENNEDY. Yes, sir. Are you telling me that what you want is gold-plated?

Excuse me, my time is up. But my point is that we could work together much more closely, General, and be able to solve some of these problems.

Administrator TURNAGE. I'd really like to do that, sir. Count on my trying.

Mr. MONTGOMERY. After that statement, Private Kennedy, you have been promoted to a little higher rank.

[Laughter.]

Mr. MONTGOMERY. Chris Smith?

Mr. SMITH OF NEW JERSEY. Thank you, Mr. Chairman.

General Turnage, Dr. Gronvall, Mr. Cole, welcome to the committee. I think it was very wise of the Chairman to have you testify in midstream so that you could hear some of the comments and recommendations made by some of your colleagues. I have found it most useful to look ahead and read some of the testimony by some of those who will appear after your testimony.

Some of the testimony that I read had some very disturbing information. It was by Dr. Paul Schafer, the executive director of the National Association of VA Physicians. He claims, as we've heard in some of the testimony earlier, that in many VA facilities physicians must treat patients with substandard equipment. I think, Dr. Gronvall, you made the point that there has been a lower level of replacement; and you did say, General Turnage, "It does worry me." So it is obviously a concern of yours.

I think what we need to do, though, is to establish how large a concern it is in terms of the problem and what we can do to fix it. Dr. Schafer points out—and again, I find this very disturbing—that at one VA Medical Center, 20 of the 25 kidney dialysis machines are obsolete and inadequate. He makes the point that respiratory therapy ventilators are largely obsolete; radiological services have placed limits on the diagnostic services they are able to perform; and he goes through a whole list of deficiencies that, it could be presumed, are providing inadequate care or at least not the best possible care that veterans deserve.

I was wondering, since some of the money is being shifted from accounts that would be used to fix and update this equipment, how does the VA plan in the future to try to, one, assess the problem? And then methodically, coming to the Congress via your budget, to fix this so that over the next 10 years we can systematically replace this deficient machinery?

Administrator TURNAGE. I think, Mr. Smith, that I can't speak, of course, to the specific instances that Dr. Schafer cites in his testimony. I haven't read the testimony and I don't know what Medical Centers he refers to, so those are illustrative and I can't speak to those. But the real generic question that you asked had to do with equipment replacement.

I think that's a complicated question to answer. Each year we document requests for equipment that come from the individual Medical Centers. Those are reviewed through our chain of command and that results in an approved list of equipment needs, both new equipment and replacement of existing equipment. That list that we keep up every year is the basis of the budget request that we prepare, which then starts through the Executive Branch review process.

I think unfortunately what has tended to happen, and it's perhaps been made worse in the past couple of years, is that as the stringency of the overall Federal budget has increased remarkably, one of the first places that is always looked to by the people who are either making up budgets or making appropriations is to cannibalize equipment money, capital investment money, with the feeling that that will allow us to put that into the operation, maintain our operation, and then there will be a brighter day; and once we get past this tight time the problem will be eased and we can go back to buying equipment.

I think there is evidence that that backlog of unfunded equipment needs has been growing year by year. It was specifically worsened in fiscal year 1989 by the budget summit agreement. That agreement—and again, I think it is important for us, as the committee members themselves have done, to go back to that agreement because that agreement set out, prior to the time that there was even an Executive Branch decision on the size of the budget request, a strict limit of 2 percent on the increased request for all Federal discretionary programs in fiscal year 1989 compared to fiscal year 1988. Once that agreement was adopted in November of 1987 by the Congress and the Executive Branch, the budget request that we had submitted for review at OMB that previous September was explicitly overtaken by that event, and that to a very considerable extent then determined the size of the aggregate request that was made in the President's budget for fiscal year 1989 for medical care, being defined as one of the discretionary programs subject to that 2 percent limit. It carried with it, as I have already emphasized, the prohibition of even considering further funding. Mr. Kennedy has chastised us for not asking, but the fact is when we are explicitly directed by the Congress and the President to not ask for additional funding during the course of the year, I think we take that seriously and attempt to plan our operation on that basis.

So there are equipment needs. We do have figures of what that backlog is. Some would say that's subject to some judgment, and there can be argument about the size of it, but it is a significant need. It was accentuated this year, as I say, by the budget summit agreement problem and my own judgment is that, given the total amount of money available to the VA, a larger proportion of it—if the pool can be increased—a somewhat larger proportion of it should be invested in equipment. But this year, in order to pre-

serve the mandated staff levels that are prescribed in the appropriations bill and meet some of the other specific targets established for us, we were forced to reallocate that money internally to other needs.

Mr. SMITH OF NEW JERSEY. Can that data bank, that information regarding the unmet need, be made available to this committee?

Administrator TURNAGE. Yes. The data are, of course, available.

Mr. SMITH OF NEW JERSEY. That would be very helpful, I think.

I'm not sure, Mr. Chairman, that we have that available to us.

That would be just to determine where the needs are and how we can best help you accommodate those needs.

(Subsequently, the Veterans' Administration furnished the following information:)

Object 31 equipment is personal property of a durable nature which normally has a useful period of service of at least one year. Replacement equipment levels are determined in accordance with prescribed equipment life expectancy tables and use standards. Each year:

—The field submits an updated replacement equipment report (LOG 1 Report #085) to VA Central Office (via the Supply Service). It contains prior year backlog, current year requirements plus 5 years. This raw data is used to generate budget initiatives for capital equipment.

—The prescribed standards require that equipment items be repaired, refinished, or refurbished and continued in service as long as economically feasible. The majority of medical equipment should be replaced within 5 to 10 years after being placed in use.

The following Equipment Replacement Recap chart provides the field input received in December 1986. This information was used to develop the replacement equipment requirement levels that fed into the FY 1989 budget process. This field based information provided the prior year carry over (backlog that existed at the end of the last actual year, in this case at the end of FY 1986) plus the value of the new equipment requirements that were expected to be replaced in the current year (1987) and 5 years thereafter (1988-1992).

From a budgeting standpoint, the prior year backlog plus the new year requirements to be replaced represent the total replacement requirements in a given year. A backlog results after applying the budgeted amount towards the total requirements. This backlog is then carried forward to the next fiscal year. The chart below describes this process

	$ Value of Equipment	
	FY-1	FY-2
Backlog from prior year	A	D
Plus: New Year Requirements	B	E
Total Replacement Requirements	A+B	D+E
Less: Budgeted Amount	-C	-F
Backlog, End of Year	D	G

In summary, the field input provides the first three lines (the initial backlog, plus each year's new requirement) to which the approved budgeted amount in any given year is applied (the larger the budgeted amount, the smaller the backlog). The resultant end of year backlog is carried forward to the next year's new requirement.

Equipment Replacement Recap

Fiscal Year 1987 Requirements	$202,526,355
Prior Year Replacement Requirements	296,552,630
Current FY 1987 Replacement Requirements (line 1+2)	499,078,985
Current FY 1987 Replacement Requirements	303,923,841
Current FY 1987 Replacement Requirements	261,160,917
Current FY 1987 Replacement Requirements	198,765,952

Current FY 1987 Replacement Requirements	136,004,951
Current FY 1987 Replacement Requirements	221,630,361

Mr. SMITH OF NEW JERSEY. I have a couple other questions. I know my time is up but if I could ask one more I would appreciate it, Mr. Chairman.

Mr. MONTGOMERY. Go ahead. I've let other Members go over their time, and you certainly may.

Mr. SMITH OF NEW JERSEY. Thank you, Mr. Chairman.

I have one other question with regard to outpatient clinics. Again, I want to thank you for your help in securing the outpatient clinic in central New Jersey. It's something I've been working on and have felt was quite needed for the last 6 years.

Again, there was something in Dr. Schafer's testimony that disturbed me, and if you could verify or tell us that it's wrong, I would appreciate it. It says, "Perhaps the most disheartening and most hazardous for their veteran patients"—speaking of the doctors—"orders are now out that outpatient appointments are to be curtailed, and those that have to be made should be scheduled as far into the future as possible."

Is there some kind of directive——

Administrator TURNAGE. No such order has been given from Washington. If there is any such order, I would assume it must be at a local level, and I am unaware of it.

Mr. SMITH OF NEW JERSEY. I thank you.

Mr. MONTGOMERY. Thank you, Chris.

Lane Evans of Illinois?

Mr. EVANS. Thank you, Mr. Chairman.

I think today we've probably heard the best evidence, Mr. Chairman, that we need to elevate the head of the VA to cabinet level status so that he has equal bargaining power, you might say, with the Office of Management and Budget and doesn't need Sonny Montgomery and Gerry Solomon to go with him. But we do appreciate your trying to advocate for the veterans, General.

My area that I would like to comment on before I get into some questions goes to notice. I am thankful that the VA has reinstated Category B and C service to veterans with non-service connected problems at the outpatient clinic in Iowa City, Iowa, but quite frankly before it was scheduled to terminate we were given about 3 or 4 days' notice in my office, if I recall, and that simply is not sufficient to help a group of people who are poor in my neck of the woods, with the unemployment problems that we're h+aving. They're out of work and really have no other place to turn to.

I understand this may also have gone on at the same time in San Diego and Boise, Idaho as well. I don't know if it is still continuing there or not. I don't know what, if any, notice the veterans in those areas got in terms of the termination of those outpatient services, but even though I could have supplied you with 1,000 eastern Iowa and western Illinois veterans who would have been terminated, I could have found out that information. I know that we all speak for a lot of veterans who are politically unconnected, who perhaps don't know who their Congressmen are, don't know that they can contact them. Maybe, speaking of my generation of veterans, they are perhaps even reluctant to call their Congressmen. Even though we may not have thousands of names—although the Chairman

says he's got a good list—that doesn't mean that there aren't people who have been hurt who don't know where to turn.

I understand that you have regional problems. I alluded to the problems in Las Vegas and in Nevada generally. I know they are planning problems, but I think we need better notice than just a few days about how it is impacting us locally.

So I would urge you to deal with this. I think your feeling, that we are taking you before the committee and that this is not the right kind of forum—I don't know any other forum that we have when we are given 3 or 4 days' notice to make you aware of our concerns, and I think that is why the Chairman has held this hearing and why we have had such bipartisan concern.

So those are my comments. I do have a few questions I would like to add.

The committee survey revealed that the VA Medical Center directors had consistently used nonrecurring funds in maintenance and repair to finance underfunded pay incentives, including special salary rates and other personnel costs. Now, what is your policy on such actions for fiscal year1989?

Administrator TURNAGE. You are quite right in stating that that has been a necessity. In fiscal year 1988, for example, the appropriation act as originally passed mandated an explicit number of dollars, along with the staffing level that must be accomplished in fiscal year 1988. Out of the appropriation that we had then, we had no choice but to reprogram dollars into the personal services account to achieve that target.

Mr. EVANS. I understand that, but I'm calling——

Administrator TURNAGE. For fiscal year 1989 I can't answer yet because those decisions have not been made. On the basis of the appropriation that has been adopted we have given preliminary budget figures to our Medical Centers; that has been referred to as the "target allowance," but that has only been on a preliminary basis. We are right now working on reviewing a set of management actions that we can take in fiscal year 1989 to ensure that our program commitments and our appropriation size match. It will only be when we have taken those actions and acted on those options, and then communicated that to the Medical Centers, that they will have their final marching orders for fiscal year 1989.

Mr. EVANS. General, is it correct that you called for the responsibility for expending nonrecurring maintenance funds to be shifted from DM&S to the Director of the Office of Facilities? Is that correct?

Administrator TURNAGE. I can't answer that but I think I can get it for you.

Mr. EVANS. All right.

Administrator TURNAGE. Did you hear the question?

Colonel DE WIRE. Yes, sir, I did hear the question.

Administrator TURNAGE. This is Col. Jim De Wire, who is the Chief of Staff of the Veterans' Administration.

Colonel DE WIRE. That is not correct. There was a proposal put forward to transfer the funding for nonrecurring maintenance from DM&S to the Office of Facilities. In fact, what has evolved is an agreement that the coordinated expenditure of those funds—where the appropriation is still in the medical care appropriation

but there is coordination on the commitment of those funds, we maintain the flexibility within DM&S to transfer funds as the need may arise during the year.

Mr. EVANS. An agreement so that there is coordination between the Director, Office of Facilities and D&MS? Is that right?

Colonel DE WIRE. Yes, and the Chief Medical Director, on the obligation and expenditure of those funds to make sure that they are consistent with the operating plan in the Medical Center and also that there are no other contingent obligations or commitments for those funds.

Mr. EVANS. Well, Dr. Gronvall, are you satisfied with that agreement, that it will give you sufficient flexibility to make up for some of the shortfalls that you have been facing?

Dr. GRONVALL. Yes. I approved the agreement that we worked out, a collaborative way that both the department and the Office of Facilities would be involved in those allocation decisions.

Mr. EVANS. All right.

Thank you, Mr. Chairman.

Dr. GRONVALL. Mr. Evans, if I may—and Mr. Chairman, with your indulgence—Mr. Evans opened with a very detailed comment about outpatient care and a very strong criticism of the VA in regard to notice to veterans.

Let me say that the actions taken by several individual Medical Centers, including Iowa City, were done unilaterally at the Medical Center level. Those actions were not mandated by the Central Office or known to the Central Office. We give to the individual Medical Center the responsibility for reviewing every veteran who applies for care, and then making a medical determination about what care is needed, and then an administrative decision about whether the Medical Center can provide the care or whether the eligibility category of the veteran either mandates the care or puts it into a discretionary category.

Mr. EVANS. Well, this——

Dr. GRONVALL. If I may finish the answer, because you made a long comment about it——

Mr. MONTGOMERY. You'll have to shorten your answers, Dr. Gronvall, or we'll never get through.

Dr. GRONVALL. Okay.

Each Medical Center on a case-by-case basis has that authority to make those decisions. Late this year, as a result of tight funds, several Medical Centers initiated by policy—or were about to—a statement that they would not, by policy, care for Category B or C veterans. When we became aware of that we contacted the Medical Centers, directed them not to issue any such policy, and to continue their case-by-case decision-making as all Medical Centers do.

Mr. EVANS. All right. Is that no longer happening, then, in San Diego and Boise?

Administrator TURNAGE. Correct.

Mr. EVANS. All right. Thank you.

Mr. MONTGOMERY. Let me follow up on something. Colonel De Wire said that nonrecurring maintenance funds might be changed, where the Director of Facilities would have to come to your office, Dr. Gronvall, or come to the Administrator if you wanted to change these funds around, to get permission. As I un-

derstand it right now, the director of the hospital can do that on his own. Wouldn't that be putting more restrictions on the individual who is running that hospital?

Dr. GRONVALL. Out of the total available appropriation in medical care for nonrecurring maintenance, our Medical Center directors have never had unilateral authority to commit and obligate those funds. There has to be a budget plan developed for how that money is going to be allocated and spent, so that requires Central Office decisions. The agreement that has been worked out is for a process involving both the Office of Facilities and the Department of Medicine and Surgery in those overall allocations.

Mr. MONTGOMERY. All right.

Dr. Gronvall, they don't have this authority at the hospitals now?

Dr. GRONVALL. Once there is an allocation of funds within the individual Medical Center, the Medical Center director has considerable discretion about how they are used.

I think what we ought to do is supply for the record the details of the budget and approval process for the nonrecurring maintenance funds that are now in existence.

[See p. 163.]

Mr. MONTGOMERY. Okay. Thank you very much.

I didn't mean to cut you off, Dr. Gronvall.

Ken Gray?

Mr. GRAY. Thank you, Mr. Chairman. I want to apologize to you and the other Members and our panel for being late. I had to stay on the House floor and get unanimous consent on some of the parliamentary procedures. They asked me to stay over, and I apologize to the General and his associates for not being here, so I'm kind of flying blind.

I would like to tell you, General, that on the 29th day of August I asked my field representative to call six of the midwestern VA hospitals. We asked eight questions, and I'll run through these very hurriedly to give you an idea of what's happening out there in the field.

We said to all six managers of these hospitals, "Are you experiencing any nonperformance or delay in providing surgery?" Five of them said yes, there is delay.

Second, "Any closure of beds or wards?" Four of them said yes, that they had closed intensive care beds.

The third question, "Is there a long return time for outpatient treatment appointments?" Five of them said yes, there is a long time for outpatient treatment for people before they can return.

The fourth question, "Is there adequate funding for nursing home care?" Five of them said they were within budget only because of instances where they would normally allow 6 months, they reduced the time to 3 or 4 months. So you can see that the vise is being squeezed very tightly.

"Is your hospital denying care to any veteran?" Almost all of them said they were attempting to treat all veterans coming to the hospital, but that they would probably be more lenient if they had more funding. We heard testimony earlier today without question, particularly from the Chicago VA manager, saying that he is turn-

ing people away and sending them into Medicare, which is just forcing a further financial burden on the civilian hospital.

Six, "Is there a lack of funding for your pharmacy?" And all six of them said yes, that this is a major, major problem. They emphasized by saying it was a "major problem" twice.

Seven, "What about funding for artificial limbs?" They said, "We are not able to provide what we should, and we are delaying a lot of requests now."

The last question that we asked, "Does your facility have sufficient funding for medical supplies and equipment?" And five of them said, "No, we do not."

On the seventh question we found a veteran by the name of Larry Baker of Benton, Illinois, a Vietnam veteran who lost his left leg, and the doctor at the Jefferson Barracks, MO Hospital in St. Louis told him that they had no money for an artificial limb. They measured him in June of this year—here's a veteran who lost a leg—and as of September 1st, when we checked on this, he has not received the leg. In calling the hospital ourselves we were told, "We have a severe funding shortage; if we get our fiscal year 1989 funds on October 1st, we will still be $200,000 in debt. We cannot promise this veteran when we can give him his prosthesis."

We also asked them about the repair—I want you to listen to this, General—we asked them about the repair. He had left his old prosthesis there to be repaired last June and was walking on a crutch. They said they couldn't get this out from the manufacturer because they didn't even have the money to pay for the maintenance of the old one.

This is a veteran who lost his leg, Mr. Chairman, in the Vietnam War.

I would be glad to turn these questions and answers over to any of your staff. We called six of the midwestern VA hospitals, one in my district and five in the northern part of the State, and it's almost unanimous that each one of them is suffering from a lack of funds.

I've always been of a mind, being around here for 34 years off and on, that you can attract a lot more flies with sugar than you can with vinegar. I didn't come here today to beat up on you, but I think we are being like the ostrich with its head in the sand if we don't recognize that we are not funding these hospitals properly to give the best of care. I know that you're working diligently and that you're working within constraints put on you by the OMB, but I think that without a doubt the record—as the lawyers would say, the preponderance of the evidence is that a lot of veterans are being turned away, a lot of veterans are getting substandard care, a lot of veterans are foregoing surgery that is badly needed, a lot of veterans are being pushed off into hospitals under Medicare without even the deductible to pay to get that care. I would suggest that you call in all these regional managers who told us very freely on the telephone that they do have these problems, and I'm sure you will find it in other parts of the country, and see if we can't all get our heads together here and determine how best to solve the problem.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you very much, Ken. I appreciate your coming back. I know you spend a lot of time on the House floor. Thank you for being with this committee.

Does anybody want to answer that?

Administrator TURNAGE. I think it is consistent with what we said earlier, Mr. Chairman. We know we've got dollar problems, particularly toward the end of the fiscal year. We think we have identified why. We have also asked the indulgence of this committee and your assistance to help us resolve it before the next fiscal year starts, and we will work with you.

With regard to the one individual with the prosthetic——

Mr. GRAY. His phone number is on this sheet of paper.

Administrator TURNAGE. We'll take it. That's absolutely ludicrous. We will do something about it, sir, and we will report to you what it is.

(Subsequently, the Veterans' Administration furnished the following information:)

On September 9, 1988, the Veterans' Administration authorized the necessary funds to purchase the prescribed artificial leg for the veteran. The Chief, Prosthetic Treatment Center at the St. Louis, Missouri, VA Medical Center called the veteran to advise him of this development and also called the contractor making the limb abd obtained a promise of an early delivery.

Mr. GRAY. Thank you. I appreciate it.

Mr. MONTGOMERY. Thank you. If there are no further comments or questions, thank you, General Turnage, Dr. Gronvall, and the other gentlemen.

Administrator TURNAGE. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Now we are getting further into the panels. What time do they cut the lights off around here?

[Laughter.]

Mr. MONTGOMERY. We're going to make this next one a panel. Dr. Don Custis—Admiral Custis, you've gotten a lot of awards; we're going to give you another medal here for sticking around that long, so come on up. If you don't mind, we'd like to have Dr. Paul Schafer, who is executive director of the National Association of VA Physicians, who has been a very strong person, and Ms. Gloria Hope—I see she has moved right in, Ph.D., Dr. Hope—former director of Governmental Affairs, American Nurses Association.

We are very glad to have you, and with all the sincerity I have I thank you for waiting around and being patient. As I told my colleagues earlier on this subcommittee, we're going to be working a lot of nights around here. We have 17 days from today to complete the legislative agenda, so we're going to be around here a lot of hours in the evening. Thank you again for being here.

I want to ask my comrade veterans if they would think about summarizing their statements. Mr. Solomon and I will certainly understand it.

Dr. Custis, do you want to start?

STATEMENT OF DONALD CUSTIS, M.D., FORMER CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

Dr. CUSTIS. Thank you, Mr. Chairman.

Before I say anything, I would like to lay claim to being a congenital optimist. I am not negative-minded. I am a strong advocate of the VA health care system, and I also feel I have earned the right to bash OMB.

[Laughter.]

Dr. CUSTIS. Having said that, I appreciate the opportunity to add my voice to those expressing to this committee their concern regarding the critical shortfalls in the quality and quantity of current services throughout the VA health care delivery system and the viability of the system in the future.

As the staff editor of the Veterans Service Organizations' annual independent budget, my information is derived from our retrieval and analysis of DM&S operational data and ongoing monitoring of medical services at the local facility level. Many indicators of declining health care services were cited in the fiscal year 1989 independent budget, together with anecdotal examples encountered through a telephone survey of 21 VA hospitals conducted in November of last year. It was then reported that while outpatient workload had increased, underfunding and understaffing had led to unreasonable queuing in ambulatory clinics and denial of outpatient care to many Category A non-service connected, medically indigent patients whose timely outpatient care would otherwise obviate their future hospitalizations.

Funds for prosthetic appliances were in critical short supply at that time. Some hospitals reported an inability to provide expensive elective surgery. Reprogramming of equipment funds had caused a backlog of almost $1 billion in acquisition requests for replacement of outdated equipment. The purchase of new and expensive high technology was considered to be prohibitive. Subsequent surveys suggest that the VA medical care delivery across the system continues to be caught in a rapidly descending spiral that is now reaching crisis proportions.

In the past several years VA Central Office managers and Medical Center directors have been able to adapt to the protracted dilemma of ever-increasing demand for care in the face of ever-decreasing resources by reprogramming funds from such other accounts as equipment and plant maintenance and repair to cover their payroll and bolster their medical care capability. Although these management options that they resorted to were ultimately self defeating, they at least deserve recognition for their resourcefulness and courage under the stress of having to live within their inadequate budgets. Now, however, their administrative flexibility is largely gone and they face either deficit spending or still more drastic reductions in patient services.

In any case, Mr. Chairman, it is abundantly clear that a quick fix is needed. The serious understaffing of nurses and certain other allied professionals is also a problem common to the private medical sector, as has been described this afternoon. So critical is the nurse shortage in the VA that it alone accounts for thousands of closed beds, cutbacks in operating room time, and limitations on special therapeutic services. It is gratifying that the Congress is already giving further attention to that problem.

Current understaffing accounts for only a portion of the closed beds across the VA hospital and nursing home system. A phantom

bed phenomenon is also involved, beds which no longer exist, although they are still included in the total bed count out of a dishonest deference to the statutory 90,000-bed level. Under such circumstances the figures for percentages of bed occupancy must be grossly invalid. So fluid is the situation that it is doubtful that Central Office ever has an accurate count at any given time of how many beds are truly operational, or to what extent workload potential is compromised.

The solution to this problem should not include removal of the mandated bed level. Both it and the floor under the FTE level were put there by Congress for exceedingly good reasons, to which OMB can attest.

Virtually no progress at all has thus far been accomplished in converting excess acute hospital beds to nursing home units. Whereas the 1988 average daily census of veterans in nursing homes—VA-owned, community, and State—was 34,000, that number is expected to reach 37,000 by 1995. The VA and the Nation will be ill prepared to meet this aging impact. There are secondary care VA hospitals in geographic proximity to tertiary care facilities which could be totally converted to nursing homes.

Mr. Chairman, veterans are grateful to this committee for its steadfast support of their health care system. They are mindful also that it is a national asset in the Nation's health manpower production effort and in medical research capability. In general, staff personnel in the VA health care system have heretofore enjoyed a justifiable pride in the high quality of care provided their patients and the professional satisfaction from the opportunity to practice state of the art medicine. Now, for the first time, I am convinced that there has developed across the entire system a nagging concern that such pride and satisfaction may no longer be justified.

If circumstances should ever develop in which this system could no longer be maintained in a manner providing the caliber of health care commensurate with the highest national standards of quality assurance, it would be far better that the entire system be dismantled. Today, out of concern for tomorrow, the VA health care delivery system particularly needs and deserves your help.

May I also say, Mr. Chairman, that I think the afternoon has been very worthwhile, and I congratulate you on your effort.

[The prepared statement of Dr. Custis appears on p. 169.]

Mr. MONTGOMERY. Thank you, Dr. Custis. I will have a question or two. I appreciate very much your strong statement. I want to make another comment or two after we've heard from the other two witnesses.

Dr. Schafer?

STATEMENT OF PAUL SCHAFER, M.D., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS

Dr. SCHAFER. Mr. Chairman, I have submitted a rather lengthy statement which I will only highlight——

Mr. MONTGOMERY. Thank you very much.

Dr. SCHAFER (Continuing). But I would like it included in the record.

Mr. MONTGOMERY. It will be included, without objection.

Dr. SCHAFER. It reviews the history of the veterans' medical program from which one can draw parallels with our present situation. I have developed these in considerable detail under three headings.

(1) Money: far too little of it;

(2) Management: too much of it, and much of it is bad; and

(3) Mean-spiritedness.

The managing editor of U.S. Medicine, on hearing such discussions at NAVAP's 14th annual meeting this past June 4th, was moved to send a 10-point questionnaire to all VA facility chiefs of staff in the system. Their responses will be featured in the August and September issues of that publication. The text of these articles has been given to me with permission to include them in my submitted testimony; this I have done. I am sure you will find them to be as revealing as I have.

[See p. 187].

I have also included a histogram as the last page of my testimony. It illustrates the little-remarked but near revolutionary change which is occurring in VA physician staffing.

This is what happened in 1987; 1,832 physicians left the system and 1,888 were hired, but this numerical replacement was far from a quality replacement. Among the 1,832 who left, 575 were senior experienced physicians, 440 of whom were certified by their professional boards, while only a handful of their replacements were board-certified. This is in no way meant to be critical of them. It is merely to underline the fact that today, only a few can be counted on to elect careers in service with the veterans' medical program. These are bright young men and women physicians who in all possible ways should be encouraged to stay with us. What we are exposing them to now hardly serves that purpose.

I have enumerated much of this, beginning with the fact that in the last quarter of fiscal year 1988 they work in VA Medical Centers that have very nearly run out of money.

Perhaps most disheartening and most hazardous for their patients, orders are now out that outpatient appointments are to be curtailed. Some veterans, under these stringencies, are going to be lost to follow-up, and some will die needlessly. But perhaps most devastating, they will have served with a staff of health care providers who each day wonder what next will befall this once-wonderful system which provided such first class, high quality care for veterans. They question if we are not now moving to a time when the practice of medicine for veterans will validly be regarded as being second class, or even third class.

Can you fault a bright young man or woman physician who plans for a career elsewhere than in the veterans' medical program? That, my friends, is the challenge that we face together.

Maybe the elevation of Veterans' Affairs to cabinet status is the time to do it.

Effective management practices must be put in place. Too many cooks spoil even a good broth.

Section 4108—Title 38, with its unfettered and unqualified delegation of authority, must be replaced by modern personnel practices.

The new Department of Veterans' Affairs must have leadership of the character and competence akin to that of Bradley, Hawley, Magnusen, and the early CMD's who followed.

Now, you might ask that if things are as bad as they seem, why even try for a fix? The answer to that question is that most of what ails the veterans' medical program is but a reflection of the larger society in which we live. We need to make every effort to have the VA health care delivery system live up to its prior promise because it has the potential for becoming one of the models which America must have if we are to meet the unmet health care needs of all of our citizens. In our pluralistic society, some of its features may be found more attractive than those of the failing health maintenance organizations of the private sector, the insurance companies' money machines, or the health care enforcement plans of corporate America.

Again, I thank you for this opportunity.

[The prepared statement of Dr. Schafer appears on p. 176.]

Mr. MONTGOMERY. Thank you, Dr. Schafer. You always do a super job. Thank you for the points you've given us, and we'll have some comments and questions after we hear from Ms. Hope.

STATEMENT OF GLORIA HOPE, FORMER DIRECTOR OF GOVERNMENTAL AFFAIRS, AMERICAN NURSES ASSOCIATION

Ms. HOPE. Thank you, Mr. Chairman.

I previously served as the deputy director of the VA Nursing Service and during that tenure never had the opportunity to present testimony before this group. I am pleased today to see that nurses were included, both from within the VA as well as outside.

More recently, as you indicated, I served as the director of the American Nurses Association's Department of Governmental Affairs, and I thank you on behalf of our 188,000 members and the 40,000 members of the Association of Operating Room Nurses for this opportunity to address veterans' health issues and health personnel-related matters.

The ANA has represented the VA nurses' collective bargaining unit since 1967 through its State Nurses Association. As we've heard today, the private sector responded to changes in medical reimbursement, patient acuity, and health care manpower concerns, and the VA has been unable to compete, especially in nursing recruitment and retention. A shortage of registered nurses also often leads to the inefficient use of hospital facilities, as we have heard from the prior individuals who have testified.

The American Nurses Association and the Association of Operating Room Nurses have observed many of the same impacts throughout the VA's national medical care centers. The examples have been vividly portrayed and depicted by all the previous speakers, and particularly so by my nurse colleague. VA Medical Centers from Boston to California have had to utilize agency nurses for overtime, and costs have been dramatically increased. Inadequate staffing means that several VA hospitals are unable to fully staff critical care units. The effects are not felt solely in acute care facilities; at some nursing homes, bed capacity must be limited as well. Increased medical needs of AIDS patients, particularly those

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requiring psychiatric intervention, have been causing difficulty in staffing the psychiatric units where most usually the care modalities are done in groups. Reportedly, some veterans are experiencing delays in clinic appointments, admissions, emergency care units, and for laboratory work.

VA hospitals cannot compete with private hospitals. In Boston not only can RN's make more money outside the VA, but the LPN's, the nursing assistants, and the ward clerks can as well. I can hardly imagine a VA hospital that has just one ward clerk for the evening tour of duty.

Special salary rates continue to lag behind because the VA cannot respond quickly.

VA personnel policies regarding overtime limits and prohibiting outside professional work also curtail nurses' earning capacity. The VA also restricts the overtime to a cap of $20 per hour.

Nurses complain about the lack of in-service programs and continuing education. Personnel budgets do not match personnel ceilings. Budgets do not reflect patient care acuity and need. Nurses are exhausted from overtime and from delaying vacations. We agree that nurse retention is directly related to workload, tuition reimbursement, and continuing education. The VA must furnish adequate support staff to nurses. Patient care is compromised by exhausted nurses. The VA Administrator must request necessary funds for personnel recruitment and retention programs, and we urge continued funding for tuition reimbursement and the health scholarship program.

The VA must also review its policy regarding professional moonlighting and consider increasing the overtime cap. We recommend that all Registered Nurses be exempt from salary limits, as provided in Title 38.

Although this committee has no jurisdiction over OPM, the OPM has the responsibility of classifying and establishing standards for non-Title 38 care personnel, and OPM could be more effective and responsive to the health care demands of Government health care systems if it employed a nurse at the policy level.

In closing, the American Nurses Association and the Association of Operating Room Nurses reiterate our commitment to assuring quality nursing care to our Nation's veterans. We pledge to work with the VA. We hope that these hearings will help maintain the ability of the VA to provide quality health care.

Thank you again for the opportunity to present our concerns and recommendations. A longer statement has been submitted for the record.

[The prepared statement of Ms. Hope appears on p. 195.]

Mr. MONTGOMERY. Without objection your full statement will be put in the record. Thank you very much for summarizing.

I have a couple of questions, but let me first thank the witnesses for this excellent testimony. I'm sorry it has to be late in the evening; I would have liked for the full House to have heard your testimony, but sometimes it works out like this as far as timing is concerned.

Dr. Custis, maybe I missed part of what you were saying. What is the remedy? I think we know that we've got to tackle this situation, and dismantling it is not the way to go.

Dr. CUSTIS. The remedy as far as where we go in the future?

Mr. MONTGOMERY. Yes, just talking about the health care system.

Dr. CUSTIS. Well, I think everyone agrees that it's going to be difficult to find the dollars to meet the need on the American health care scene in any of the pluralistic sectors, and that certainly includes the Federal health care systems.

From what I read in the medical literature I sense that the Congress is very likely going to address such things as long-term care. There is a lot of advocacy now that is reflected in the literature now that the time has come for taking a hard look at the very structure of Medicare/Medicaid and doing something about that. State legislatures are already considering such options as Massachusetts has already enacted, mandated employee-based health insurance. If these things come to fruition and it should happen that health policy is seriously addressed by the Congress, that certainly is also the time to take a hard look at the VA health care system. I think that most of us would agree that some realignment is necessary. There are hospitals that are not efficient. There are hospitals that could be converted to nursing homes, and certainly, the need for nursing homes in the very near future is going to be very great. There are hospitals that could be closed, where they are in geographic proximity to a tertiary care hospital 15 or 20 minutes down the road. Some of those secondary hospitals now, under the incentive of DRG's, are actually taking on tertiary care.

It seems to me that it's going to be very important, and some strategic planning for the future of the system, to really know what the unmet entitled need of the VA health care system is. OMB, in our past efforts when I was there, would never permit us to survey that unmet need. It's something that's got to be done, especially if the Congress is going to look at eliminating the uninsured and uncompensated care——

Mr. MONTGOMERY. On that other statement that you made about OMB, Mr. Solomon and I have requested the General Accounting Office to make a study of what you were just commenting on.

Dr. CUSTIS. That will be a valuable study, but I think it could even go further than it is going.

There are medically indigent veterans who have never made use of the system, who have never been seen in the system for one reason or another. We have no idea what that volume is. I think the GAO study will be focused on the means test and the traffic that comes to veterans' hospitals that is not accommodated. Is it more than that?

Mr. MONTGOMERY. It covers more than that, Dr. Custis.

Are you through, sir? I had another question.

Dr. CUSTIS. That's as close as I could answer your question.

Mr. MONTGOMERY. Dr. Schafer, to follow up on the question to Dr. Custis, I believe you said that "money, management, and mean-spirited action" would do the job?

Dr. SCHAFER. On the matter of money, it has always seemed strange to me that our society, increasingly with each passing year as we move away from the last adventure, seems to forget that veterans really are part of the cost of war. And until such time as

that is made very clear, it is unlikely that we will see veterans receiving their fair share of the money that really is rightfully theirs.

We have just lavished unimaginable treasure on our Department of Defense, and yet in terms of veterans' health care we only are getting the equivalent of 10 days out of the whole year if you look at the cost of health care in this society, which is running at about $1 billion a day. So in respect to money and in respect to the values that are involved here, I think that veterans are getting very badly shortchanged.

I recognize that there are all of these many limitations and strictures and reasons why we can't ask for what we need, but I think we have got to—one way or another—ask for what we need, define what we need and ask for it.

Mr. MONTGOMERY. I would agree with that statement.

My time is up, Ms. Hope, so I am going to have to recognize these other Members, and we do have another panel.

All right, Gerry?

Mr. SOLOMON. Thank you very much, Mr. Chairman. I'm getting hoarse and I'm not even talking here.

Dr. Schafer, Dr. Custis, I just want to commend you on your statements, on your frankness and forthrightness. We certainly share your opinions. Let me just devote my time briefly to Ms. Hope.

Ms. Hope, you talked about nurse retention and you talked about nurse recruitment, but I am just so concerned that people are not going into the nursing profession. The testimony today has brought out that there is only a 60 percent enrollment in the nursing schools throughout the country. We have nursing schools closing throughout the country because of no demand for the schools.

What do we do about that? First of all, what do you think the reason is that there is only a 60 percent capacity? Why are these schools closing? Why are young men and women not going into the nursing profession?

Ms. HOPE. I believe many of my former colleagues answered the question about people wanting to control their own practice, wanting to control their own environment. I would also say that many more opportunities are open to women than had previously been. Two professions that predominantly were women professions were nursing and teaching. Understandably—maybe not so understandably—they are always the least paid salaried professional persons. Nurses are not paid commensurate with their experience and responsibility. We heard today many salaries that sounded very good as beginning salaries, and I can only tell you that if one starts at, say, $31,000 or $27,000 or some of these other figures that have been said to us, that by the time they retire after 15 or 20 years they would only be making about $10,000 more. There isn't any other profession that works for 20 years at any profession and makes only $10,000 more than a starting salary. So we are finding salary compression. Women are not going into nursing when they can go into other fields that are much more lucrative.

We often think of people who go into nursing as caring persons who like to give service. I understand that there are more women medical students today than male medical students. They can go to that caring profession and provide caring. I recently had an experi-

ence in a delivery room with a great niece, and there was a female surgeon, a female resident who performed the caesarean, a female pediatrician, and a female anesthesiologist. Now, in my day 40 years ago in a hospital, that was not the case. I think that's why women are going to other professions, why we are seeing the shortage in nursing.

Mr. SOLOMON. Thank you very much.

Mr. Chairman, I'm going to reserve the rest of my time, if I may.

Mr. MONTGOMERY. All right. Without objection. We will be certain to get that on the record, about the nurse shortage.

Do any other Members have any questions or comments?

Mr. SMITH OF NEW JERSEY. Mr. Chairman, very briefly?

Mr. MONTGOMERY. Okay, go ahead.

Mr. SMITH OF NEW JERSEY. Dr. Schafer, I think you heard me a few minutes ago when I asked Dr. Gronvall regarding those orders going out to the outpatient clinics, and you reiterated it in your own comments as well as your written statement.

Were you talking about some localized orders or something coming from the Central Office?

Dr. SCHAFER. No. I think Dr. Gronvall supported the statement I made. I did not mean to imply that there had been an order that had come out of the Central Office. I meant that in local facilities the order has gone out to do these various adjustments in clinic appointments which in effect curtails them into the future.

I would expand on that, though, that this is being done to save money in laboratory tests and in x-ray examinations and in the prescription of costly drugs from pharmacies. It is a device that is being used, and it is widely spread in the system.

Mr. SMITH OF NEW JERSEY. Just to be clear, it was my understanding based on his comments that he explicitly said that no central directive or anything of that order has gone out.

Dr. SCHAFER. Correct, and I did not mean to imply that in my testimony.

Mr. SMITH OF NEW JERSEY. Just so we can be very clear on that.

Dr. SCHAFER. Right.

Mr. SMITH OF NEW JERSEY. You attached to your testimony an article from U.S. Medicine from August that points out that "Dr. Turnage's deputy, Thomas Harvey, under questioning by VA physicians following his speech to the National Association of VA Physicians a month earlier, acknowledged that a problem with Turnage's site visits is that career employees tend to tell the Administrator what he wants to hear." And Dr. Custis, perhaps you would want to touch on this, too.

Is the boss getting misled by his own people, by the careerists? We heard from a number of directors earlier today who were very emphatic and very forthright in detailing their concerns. With what they said today, why would some of those same people, if they were visited by General Turnage, give a different view when he goes out on these types of visits? Or is this just not accurate?

Dr. SCHAFER. Having been present at the time Tom Harvey made this statement, I can only tell you that it is a very accurate statement. Of course, it is a text written by the managing editor of U.S. Medicine and I can take no responsibility for it. However, you have asked me the question. I heard the statement.

Mr. SMITH OF NEW JERSEY. So the General is not getting the kind of feedback from his own people——

Dr. SCHAFER. I heard his deputy say that.

Mr. SMITH OF NEW JERSEY. Thank you.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you.

Dr. Rowland?

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman. I will take a couple of minutes here.

Dr. Schafer touched on something that I have been exploring for some time now.

Dr. Custis, it is nice to see you again.

Dr. Hope, it is nice to have you here today.

In our country right now it seems to me that we are headed toward a national health service, that we are headed in that direction because of economic pressures. 25 years ago it was for philosophical reasons. I believe there are people in Congress right now who want us to have a national health service, and I think that if that ever develops our whole VA system will be dismantled and it will come under the national health service.

My idea has been that to provide those people who need care that can't afford it, to develop a system similar to the VA. I think it could serve as a model. There are probably about 70 percent to 75 percent of the people in this country who get their care in the private system; maybe 25 to 30 percent get their care under the Medicare/Medicaid system, or those who are retired from service. It's going to cost about $80 billion for Medicare and $23 billion for the Federal share of Medicaid. Even if it was fully funded, for one-tenth of that amount—I can assure you that the VA treats far more than one-tenth of the patients who receive medical care in this country.

So it's my feeling that the VA could be used as a model to develop a system to provide care for those people who are now getting Medicare and Medicaid, and I believe that if we don't move in that direction, doing something to provide that care, the pressures are going to continue and we'll wind up with a national health service.

Dr. Schafer, you alluded to the fact that the VA could serve as a model to provide this care, and I just couldn't pass up the opportunity to try to make that point. I've been looking into this. I've been trying to get information on it. It's extremely difficult to make real comparisons about inpatient and outpatient care, Medicare/Medicaid versus the VA, but I'm continuing to work on that. I certainly look forward to any comments that you might have—not here today because we really don't have the time, but I would like to talk more about that in the future.

Thank you very much, Mr. Chairman.

Mr. MONTGOMERY. Thank you very much.

Let me follow up on one point you made there. We're getting ready to open a State veterans' nursing home in the State of Mississippi, and it has been estimated that the State will save about $200,000 a year on Medicaid payments because of this State veterans' nursing home. So we've got some good programs out there that are in place that can save the taxpayers money in the long run, including health care in the VA hospital system.

Dr. ROWLAND OF GEORGIA. Absolutely, Mr. Chairman. You make a good point and you give a good example of exactly what I'm talking about. Dr. Custis referred to the fact that we're going to have some kind of long-term health care legislation enacted because there is so much pressure being brought to bear on Members of Congress by the people that they represent to do something about it, and something does need to be done about it. But if we continue to do the things we've done since 1965 when Medicare and Medicaid came into being, we're going to have a national health service. We're headed in that direction.

Mr. MONTGOMERY. Bob McEwen, go ahead.

Mr. MCEWEN. Dr. Custis, in your experience how does this carry over at the end of the year in the shortfall, compared with previous years?

Dr. CUSTIS. Well, I think it's much more visible and much more acute for the very reasons that have been defined this afternoon, that it is a cumulative thing.

You know, there is a deficiency in the way we develop VA budget—and other budgets too, I suppose, for that matter—but this business of current services is inherently faulty to start with. You take the previous year's appropriation and you add to it certain unavoidable expenses. However, when you get through negotiating with OMB you don't totally add all of those coming unavoidable expenses; you absorb some of them. On top of that are new programs that are legislated that oftentimes are inadequately funded. It accumulates and you build that current services on a resource base that is invalid to start with. There is a deterioration of that resource base from year to year.

Mr. MCEWEN. You have a unique vantage point on all of this. It is customary in situations like this, in which we attempt to reach forth and work together, that the VA takes somewhat of a defensive stand. They want to assure us that they have everything under control and that they're doing their best. They're taking hits from independent agencies up and down the street, so they come in here and seize their opportunity to lay them out point by point by point with statistics and graphs and charts, and it leaves us kind of in the lurch as to how to be helpful when every time we come to the VA we are assured that everything is under control.

You've been in that position for many years. What is your recommendation? How do we highlight shortages without offending those who have dedicated their lives to service to our veterans?

Dr. CUSTIS. I think it is very difficult to find a solution even though there is much need for a solution.

One of the problems is that most Federal agencies have programs that have nothing to do with the medical care of a patient, but a health care system cannot have arbitrary reductions without the end point, patient care, being affected. When arbitrary cuts are made and arbitrary absorptions in the resource base are enacted or enforced, it is felt——

Mr. MCEWEN. Okay. I am using up my time. Just one final question for you, Dr. Custis, and I have one for Dr. Schafer.

Assuming it's February, you come in, you have presented your budget, you have made the difficult discussions with your area administrators and you have done the best that you can, and a

Member of Congress asks you, "Do you feel that you can provide adequate health care with the budget that you are presenting to us this morning?" Would your answer in that circumstance not be yes?

Dr. CUSTIS. If the question were put, "What is your personal opinion," I would be candid as I have been in the past.

Mr. MCEWEN. And you would say no?

Dr. CUSTIS. But if you don't phrase it in that way, I am obliged as an employee of the Veterans' Administration in those days to support the party line. I take guidance from the President's budget.

Mr. MCEWEN. Okay. I've only got 90 seconds left. How do we resolve that? Do we have private meetings in our office, or what?

Dr. CUSTIS. I think it starts with an attitude on the part of an Administration, whether or not they permit that kind of communication.

Mr. MCEWEN. Were you ever inhibited, when asked directly——

Dr. CUSTIS. Not when asked for my personal opinion.

Mr. MCEWEN. All right. That's all I've ever asked, and I do it annually. I have been assured that they can work within those constraints.

Is there any other verbiage that I should use? Is there any other forum that I should seek?

Dr. CUSTIS. I think it's generally agreed that that's all it needs, is a request for one's personal opinion.

Mr. MCEWEN. All right. And I don't recall you, Dr. Custis, saying that the budget that you were recommending was inferior.

Dr. CUSTIS. I'm sorry, I didn't quite get that.

Mr. MCEWEN. Well, I just remembered that in our many encounters I have virtually always raised it, and I just don't recall you saying that it was inadequate. I just want to make sure that——

Dr. CUSTIS. I think that if I would search the Congressional Record I would find instances where you had asked me what my personal opinion was, and I would have said that it's not adequate.

Mr. MCEWEN. All right.

Dr. Schafer, you made a passing reference to the fact that we have "lavished" benefits upon the Department of Defense. Is that in their health care or in their pay or in their service for time away from home? Where is this lavishing taking place?

Dr. SCHAFER. I was referring to the budget of the Department of Defense. I think I made that quite specific. I am talking about the multi-trillion dollars of treasure that we have poured into our defense budget, obviously to support all of our needs for national defense. But I'm saying that veterans are an integral part of the cost of war, and if we can lavish that much treasure into——

Mr. MCEWEN. The $192 billion that you are referring to?

Dr. SCHAFER. Yes, sure. We surely ought to be able to do better than $10 billion for the veterans who have already been there and made their sacrifices.

Mr. MCEWEN. Thank you.

Dr. CUSTIS. May I contribute just one thing that I think is pertinent? It has to do with these mandated levels as far as beds and FTE's.

Dr. Gronvall identified the date of the passage of those mandates as 1981. I was the Chief Medical Director at that time. In those

years, 1980 to 1982, along about there, OMB was impounding personal service dollars after they had been appropriated, preventing the VA from fully hiring up to ceiling. Also, in the budget process they were requiring reduction of beds. Rufus will remember these days. The Congress and this committee took the initiative to mandate floors to prevent that from happening.

The interesting thing is that after I retired from the Veterans' Administration and after the very senior person in OMB also retired, he told me in retrospect that in that period of time, when David Stockman first arrived, the guidance was that we will shrink this system so that the non-service connected veteran is out of it, that the space availability to the non-service connected veteran must go, and we'll do it slowly by the budget process. That's why the Congress put the floors there. I don't think there's anything——

Mr. McEwen. That's also why we got rid of that bum.

Dr. Custis. That's right.

[Laughter.]

Dr. Custis. I don't think there's anything sacrosanct about the figure of 90,000 beds or 194,000 FTE's, but if you ever give up the Congressional right to decide what the size of that system is, and an OMB comes along that was there in the 1980 to 1984 time frame, I will wager that you will feel the need to replace the floor.

Mr. Montgomery. I want to thank the panel very much for your patience and for your excellent testimony.

Our last panel today should come forward, the great veterans' organizations: Mr. Jim Magill, director of the National Legislative Service, Veterans of Foreign Wars; David Gorman, assistant national legislative director for Medical Affairs, Disabled American Veterans; Tom Miller, director of Governmental and Community Relations, Blinded Veterans Association; Mr. Tom Sherwood, director of Health Policy and Planning, Vietnam Veterans of America, and with him Mr. Paul Egan; and Mr. Gordon Mansfield, associate executive director for Government Relations, Paralyzed Veterans of America.

Let me thank you gentlemen for your patience, and also to commend you for the legwork that you've done in terms of the surveys, and thank my colleagues for staying here so long. I appreciate my colleagues staying here. But these veterans' organizations went out and got some surveys and investigations, and they have identified what is taking place in these veterans' hospitals. It is very helpful to us in the committee.

Without objection all your statements will be put in the record, and if you could summarize, it would certainly be helpful to the subcommittee.

I would remind my colleagues that the full Committee on Veterans' Affairs goes back in session at 9:30 in the morning to take up judicial review. If I can think of anything else between now and then, I'll let you know.

[Laughter.]

Mr. Montgomery. All right, Jim, I called your name first. You go ahead.

STATEMENT OF JIM MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. MAGILL. Thank you, sir. On behalf of the entire membership of the Veterans of Foreign Wars I wish to thank you for affording us the opportunity to present our views concerning what we consider the very severe problems that are now facing the VA's DM&S.

I have already submitted for the record the VFW's statement addressing this issue, as well as an addendum which presents particular instances of diminished and/or substandard health care being provided at certain VAMC's. Rather than reading from these two documents at this time, I would like to cite additional concrete examples of the inadequate funding and management of DM&S.

For example, at Loma Linda, California, two wards closed due to nursing shortages. Six- to eight-hour ambulatory care waiting time.

New Orleans ran out of money in each quarter of this fiscal year.

Albuquerque, New Mexico, ward closed due to nursing shortages.

Wilmington, Delaware, ward closed. Long delays in outpatient scheduling.

White River Junction, Vermont, cut beds 20 percent due to nursing shortages.

Boston, 169 beds vacant due to nursing shortages.

Fayetteville, North Carolina, nursing shortages totalling 25 percent.

Reno, Nevada, two wards closed due to budget cuts. Prosthetics restricting issuances due to budget cuts.

Tolgus, Maine, a general medical ward of 38 beds closed 6 months ago due to nursing shortage.

I could go on and on on this list. It's a couple pages, but I just wanted to give you an example. I also have names of veterans who we have found have been denied care; that is also on this list. With your permission I would also like to make this a part of the record.

Mr. MONTGOMERY. Without objection.

[The information appears on p. 226.]

Mr. MONTGOMERY. If you want us to, we'll send the list to General Turnage.

Mr. MAGILL. That would be fine. I'd like him to look at it. A lot of the places that we heard about are listed here, and he said that they were "spotty" little cases. I tried, when I went through this, to pick out—I have California; I have the east; I have the south; I have the north—when you see the list you will see that it covers a wide range. With the names—I have names here now. We expect more from our staff.

That's basically all I really have to say right now, sir. I think that with my statement that I supplied, that will be of help to you.

[The prepared statement of Veterans of Foreign Wars appears on p. 213.]

Mr. MONTGOMERY. That's very helpful.

Mr. Gorman?

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman.

I want you to know at the outset that we are genuinely appreciative of the opportunity to appear today and for your scheduling these hearings, in an extremely timely manner.

We also appreciate the subcommittee's work and the staff's work that has been expended to learn and to document what is actually occurring in VA medical facilities across the country. We believe the recently-completed site visits and the results of your study of all VA medical facilities portray a clear picture and are representative of the situation occurring throughout the system today.

Mr. Chairman, notwithstanding what is clearly a critical funding problem within DM&S, we would like to extend our appreciation to those dedicated employees of the VA who have made the system work, which has allowed veterans to receive the health care services which they so desperately need and are entitled to.

With increasing frequency we are being contacted by veterans, detailing what they perceive as a cutback or denial of medical services provided by the VA. They complain of such things as actual denial of care, extremely long delays in getting prescriptions filled from the pharmacy, long waits before being seen by doctors for clinical appointments, waits of weeks or months to obtain prosthetics and prosthetic supplies, and being referred to other VA facilities long distances from their homes because of the local facility's inability to furnish appropriate treatment, many times due to lack of medical personnel.

We also hear from families of veterans who are desperate to arrange nursing home care, only to be told by the VA that there is nothing available.

We hear from veterans who are fearful about news that a clinic is closing or a program in which they have been actively participating is being terminated due to lack of funds.

Veterans contact us in distress that they are in acute need of medical treatment but they are being told by the VA to come back in three, four, or even 6 months, or go to a private doctor; and if they are forced to make that choice, veterans want to know if their emergency medical bills, sometimes totalling in the thousands of dollars, will be paid for by the VA.

Veterans contact us who are confused because they leave their homes in the early hours of the morning to keep an 8 a.m. appointment with a VA doctor, only to wait hours or all day before being seen. In some cases, we have been told, they can't see the doctor at all.

Some veterans have questions: "Why did my VA doctor tell me to go to a doctor who participates in the Medicare or Medicaid programs so I can get the medical care I need?" The answer appears to be that the veteran really does need immediate treatment and the VA lacks the resources to provide it.

Veterans also want to know what they are going to do, how they can go to work during the day because of the months they have to wait without their artificial limbs being provided by the VA,

simply because the VA doesn't have the money to buy it until the next fiscal quarter.

These are real questions, Mr. Chairman, from real veterans. Unfortunately, we cannot always provide them with the answer they want to hear or is acceptable.

Mr. Chairman, approximately 2 months ago we initiated our own survey of VA medical facilities. We have received information from our National Service Offices describing the current climate of the VA across the system. Without exception, our NSO's report that facilities within their States are facing critical budget shortages that are creating numerous problems and having an adverse effect on the facilities' ability to provide medical care to eligible veterans. The information from our study has been provided to the committee, as well as to all Members of Congress. In our view it supports the findings of the committee's own study.

Mr. Chairman, we believe the crisis in the VA Medical Centers and DM&S as a whole is that they are operating today with totally inadequate budgets, and deserving veterans are not receiving the care they require and are entitled to as a result.

That concludes my testimony, Mr. Chairman.

[The prepared statement of Mr. Gorman appears on p. 227.]

Mr. MONTGOMERY. Thank you very much, Mr. Gorman.

Tom Miller of the Blinded Veterans Association?

STATEMENT OF TOM MILLER, DIRECTOR OF GOVERNMENTAL AND COMMUNITY RELATIONS, BLINDED VETERANS ASSOCIATION

Mr. MILLER. Thank you, Mr. Chairman. As always, the Blinded Veterans Association appreciates the opportunity to appear before your distinguished subcommittee and have the opportunity to express our views. We particularly want to commend you for holding this hearing this afternoon and this evening and possibly on into the morning.

[Laughter.]

Mr. MILLER. This is an extremely important issue. Certainly, the word that I've heard more than once this afternoon has been "crisis." The Blinded Veterans Association is very, very concerned that a crisis exists in the VA health care delivery system, particularly with regards to rehabilitation for blinded veterans.

Shortly after World War II the VA assumed full responsibility for the care and rehabilitation of blinded veterans. 40 ago this past July the first blind rehabilitation center was opened at Hines VA Hospital. It is rather ironic that Mr. Fears was here to testify earlier, and that he was forced to deny a special salary rate request for blind rehabilitation specialists at his facility due to lack of funds, but he had no funds at his facility and there were none at the regional level or at the Central Office.

We have highlighted in our testimony that there is a vast number of blinded veterans waiting for admission to the blind rehabilitation program. There are eight programs in all; we have only included seven for the purposes of this testimony because the facility at San Juan, Puerto Rico is not up and running yet. It is operating as an outpatient, storefront operation at this point.

In our written statement we indicated that we discovered in a survey 2 weeks ago that there were 698 veterans awaiting admission for blind rehabilitation. Since that time I have learned that that now is up to 736. I wouldn't be surprised if, by next week, it were close to 800.

We have outlined a number of reasons why that waiting list exists and continues to grow. Part of that is due to the increased incidence of blindness and due to the increased numbers of full-time visual impairment service coordinators employed by the VA who are now able to devote full time to identifying newly-blinded veterans and plugging them into the system.

Other very important reasons that we feel are impacting that are staffing cuts, shortages, freezes on vacancies, all of which tend to delay the process of admission. All of this has a definite effect on the quality of care due to the intense pressure placed on the professionals who are teaching our blinded veterans and taking care of their rehabilitation needs.

I think I will leave the reasons for the existence of the list and the exceptionally long waits. We pointed out that a veteran may wait anywhere from 3 months to as long as 15 months for admission to the Eastern Blind Rehabilitation Center at the VAMC in West Haven, Connecticut. That program is on the critical list. There are severe problems at the entire Medical Center. The blind program there is experiencing severe problems in the overall delivery of blind rehabilitation services. They have approved special pay rates for the Blind Center at West Haven and for the Western Blind Rehabilitation Center at Palo Alto. That action went a long way to assist those facilities in filling long-existing vacancies.

With the denial of the special pay rate request for the VA Blind Center at Hines, they are now at a distinct disadvantage in competing for blind rehabilitation specialists with their sister center. A blind rehabilitation specialist would opt to go East Coast or West Coast because their pay rates would be substantially better.

Also, the VA at the Central Office level is undertaking an effort to upgrade the general schedule for blind rehabilitation specialists. We are optimistic; we have been pushing for this for a number of years and we feel that we have finally convinced them of the need, of the crisis that exists in terms of recruitment and retention, and that this would be a very effective tool to help stem that problem.

Another step that the VA has taken but has not honored—there is a VA circular which prohibits or directs that cuts—inasmuch as the VA blind rehab program is regional in nature, the local Medical Center should not take the full hit. The blind clinics or centers currently—if the Medical Center has to sustain a number of cuts in FTEE, then the Blind Rehabilitation Service is expected to take a full hit along with the other services at that local facility. We feel that, inasmuch as it is a regional program, those cuts should be spread across the region to minimize the negative impact on the blind center activity.

These are actions that the VA has initiated and we feel somewhat optimistic and hopeful that if they are implemented and acted on, they will help.

Mr. MONTGOMERY. Tom, you've had seven minutes. The Chair will give you another minute, but I've had these Members around

here all day, and you're supposed to talk 5 minutes. So you have another minute.

Mr. MILLER. Okay.

The bottom line is that the demand for care is vastly outrunning the supply. We need more beds. At a very minimum, we need to have existing facilities operational and running at capacity. If those beds were brought into operation and appropriately staffed, that would mean an additional 25 to 30 beds which are desperately needed.

That concludes my statement, Mr. Chairman.

[*The prepared statement of Mr. Miller appears on p. 232.*]

Mr. MONTGOMERY. Thank you, Mr. Miller.

Tom Sherwood, Vietnam Veterans of America?

STATEMENT OF THOMAS SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA; ACCOMPANIED BY PAUL EGAN, LEGISLATIVE DIRECTOR

Mr. SHERWOOD. Thank you, Mr. Chairman. Thanks for giving us the opportunity to address you today.

The letter that was sent to us from this committee in the past basically asked what was the main issue or problem that was confronting the Veterans' Administration. In the letter of response we said that the main problem was the quality of care. That continues to be the main problem, as we've heard very clearly today.

The problem is that as we go through this process over and over and over we really don't see a coming together in terms of the resolution of the issue. I think that the problem, in terms of its solution, is really at the level of the Medical Center. We have all of these layers, as I have defined in the paper, that really impinge on the Medical Center director and absolutely incapacitates him in terms of him making any kinds of decisions or having the ability to function. You have Central Office with its own political objectives and mandates, and the regional offices with their own political objectives and mandates—that is, the regionals in a sense sharing corporate responsibility with VA Central Office—and the district. And then of course there is OMB and all of the other kinds of institutions that impinge on the Medical Center director.

I think that the director, in terms of the recommendations that I have made here, should have the opportunity to invert the system. We've tried it with the Medical Center Efficiency Program, with the five Medical Centers. The Medical Center directors should design and construct their budgets from the beginning in terms of programs, personal services, and dollars. They should do that with a group of governing veterans that work with them at the Medical Center level. The role of the Central Office should basically be as a fiduciary intermediary; that is, they buy services from the Medical Centers for veterans, and in the purchasing of those services the Medical Centers must define what the health care product is and how best they can deliver it. I think this is a good strategy we should try.

Clearly, what we are doing now is not working. We are just going from day to day, week to week, year to year with the same continuous complaints.

I think that the issue about the ceilings—the personnel ceilings as well as the bed ceilings—once such system is in place where the Medical Center really has the full authority to manage its systems become a moot point. That is, the propped up current national bed ceiling will float automatically towards a national true bed ceiling and the same for a national personal services FTEE. This business about the personnel ceiling floor being 140,000 FTEE and the ceiling being 190,000 FTEE—in this world's complex medical health care delivery system, that indeed does approach 11 percent of the GNP makes no sense. These ceiling assignments nationally simply do not work any more. I think what we need to do is look and relook at the way we deliver services, not only as a part of the Veterans' Administration but as a part of the largest system which clearly is putting tremendous pressure on the VA system.

I'm hoping that you will look very closely at these recommendations. These are a very different kind of recommendations that one does not normally see either a public administrative system or in those of the Veterans' Administration.

Thank you very much.

[The prepared statement of Vietnam Veterans of America appears on p. 247.]

Mr. MONTGOMERY. Thank you, sir.

Our last witness is Gordon Mansfield, Paralyzed Veterans of America.

STATEMENT OF GORDON MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Mr. MANSFIELD. Mr. Chairman, first I would like to thank you, Mr. Solomon, the other Members, and the staff for holding this hearing. One of the advantages of going last is that everything that is to be said has usually been said, and I think that this date—here we are, it's 7:45—it's been said three times.

Mr. MONTGOMERY. That wraps up the meeting.

[Laughter.]

Mr. MANSFIELD. I think what we've done here is we have given public acknowledgement to a problem that we've talked about, on and off the record, for a while. I would just like to highlight three areas.

The first is that veterans are being denied care.

The second, in PVA's instance, is that we have problems in prosthetics and supplies and those types of issues. I think we have to remember that for PVA's members health care is not a luxury. It's the basis for living life. It's the difference between being stuck in a back bedroom somewhere and being out in the world, living a real life. It's the most important part of the system for us, so things like prosthetics and supplies are important.

The other thing is the quality of care. There are many parts to this. Using nonrecurring dollars for daily usage obviously is going to run us into problems further down the line. The nursing shortage we know about. We have included in this testimony that PVA surveyed over 100 Medical Centers. The report has been submitted to you.

I think the important thing is that we recognize that the people that are the center directors and the nurses that came in here today and told you and us what the situation really is are the people who are day by day, hour by hour, making the system work because of the shortfalls in resources. I would suggest to you that it will be very important that these people be included in the solution.

We know we have a problem. I congratulate the committee on bringing a heightened awareness to it. I think all we can say is, let's go forward working together to try to find the solution because the end result is that veterans are either going to get or not get the care that they've earned, and I think they should get what they've earned.

Thank you, Mr. Chairman. As a last closing thought I will mention that I am testifying tomorrow morning, and perhaps you remember a quote from the Bible, "The last shall be first."

[Laughter.]

[The prepared statement of Mr. Mansfield appears on p. 295.]

Mr. MONTGOMERY. I don't have any questions and I hope the Members don't have many questions, but let me comment—I thought that General Turnage was saying that we do have a problem. I think that you, Roy Rowland, brought up something that he was commenting on, that we have a problem and we're going to look at it. I think that's mainly what we want to get across to the Veterans' Administration. There are some problems out there, and they need some help.

I have no further questions.

Mr. MILLER. Mr. Chairman, if I may make one comment, which I forget—my Alzheimer's is catching up with me—in reference to Dr. Schafer's point in his testimony, and Mr. Smith has picked up on that, I personally received a phone call—I am an outpatient at the Medical Center here in D.C.—a week ago tonight. About 6:30 at home I received a call from the neurologist that I am under the care of at the VA Hospital. I see him twice a year for medication. He called and said that he and all their clinics were under orders to try to push back any scheduled appointments until the next fiscal year if at all possible. I had an appointment scheduled this morning, and as it turned out I will have sufficient medication supplies to last until the first week of October.

But it is a reality. If you need a name, it was me.

Mr. MONTGOMERY. Thank you, Tom, for that comment.

Mr. SOLOMON. Mr. Chairman, I just might say that I'm not going to ask any questions either because of the lateness of the hour, but we always have a running dialogue with all of your organizations. We appreciate that very much. Your help is what got us through this hearing here today too, to this point.

Sonny, I just want to commend you, really, for holding this hearing in a timely manner because I think we have some real serious problems that we have to deal with. I think we've gotten some of the answers here today, at least of where we go from here. We may not know what we're going to do, but we know where we're going to go, and that's to the White House to get some answers to try and solve these problems.

Again, I just want to thank you. I think you ought to go first tomorrow morning with this slave driver here that's kept me—I'm only an ex officio member of this subcommittee and I've been here for 6½ hours.

Thank you all for coming. We really do appreciate it.

Mr. MONTGOMERY. Thank you, Gerry.

Any other comments?

[No response.]

Mr. MONTGOMERY. Let me thank the subcommittee members, and especially those who have seen us through here at 7:40 at night. I want to thank our witnesses at the table and also thank our guests today that have been in the audience. I notice that some of you have been out there all afternoon. You have handled yourselves well. Thank you for having an interest in what's best for the veterans.

If there is no objection, this subcommittee is adjourned. The full committee will come to order at 9:30 in the morning.

[Whereupon, at 7:40 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

HONORABLE CHRISTOPHER H. SMITH, NJ

VETERANS' AFFAIRS SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

HEARING ON THE DEPARTMENT OF MEDICINE AND SURGERY OPERATING FUNDS

SEPTEMBER 7, 1988

Thank you Mr. Chairman. Mr. Chairman, this hearing today is essential in order to further clarify information regarding the status of available funds for the operation of veterans' health care services.

Most of us are familiar with the information collected from VA medical facilities during staff visits in April, 1988 and the findings of surveys collected from all VA medical centers in June, 1988. The data reveals that VA medical directors are supplied with questionable funding levels and are operating with insufficient resources to deliver health care at VA medical centers.

According to the reports of numerous VA medical center directors nationwide, a significant number of patient beds are not available to accomodate veterans who may need care. In fact, over 13,000 beds are closed nationwide, 30% of them closed because of staff or funding shortages. Hospital directors have attempted to delay bed closings and maintain quality care of shifting funds from other accounts-- such as replacement equipment and maintenance and repair accounts-- to cover the day to day expenses of running their facilities. Throughout FY' 88, over $105 million originally earmarked for other accounts has been used for recurring operating expenses at medical facilities.

Shifting funds, however, does not always alleviate the shortages whithin VA hospitals; some medical centers have still been forced to close beds. The June survey showed that 59 medical centers have temporarily closed 20% of their beds and 6 centers have closed 50% of their beds.

The real issue here is just how the funding constraints and subsequent bed closings are affecting the status of health care available to veterans. I appreciate this opportunity to further explore this matter and look forward to hearing the testimonies of our distinguished witnesses.

CONGRESSMAN LES AUCOIN

Hearing on status of Health Care Facilities
Veterans' Affairs Committee Hearing
September 7, 1988

OPENING STATEMENT

I want to thank my friend Sonny Montgomery and the rest of the Subcommittee for allowing me to be part of this investigation. I have long admired the work of this committee for meeting the acute needs and demands of the veterans' community while combatting the shrinking availability of federal dollars.

It appears that despite the hard work of this committee, our committment to American veterans is being undermined. That can't be allowed to happen. We can't sit by and watch our committment being sniped away benefit by benefit.

I am here as a member of the Appropriations Commitee to work with you, Mr. Chairman, and with the rest of your committee, to find causes and solutions.

This is the beginning of an investigation. So we don't yet have all the answers. But this much is clear. This administration seems intent on cutting its obscene budget deficits on the backs of our veterans. Where I come from, we say "Who breaks his faith, no faith is held with him." Well, if we in Congress do not act quickly, I fear our government will break faith with the men and women who we have promised to serve.

In Oregon we have a state of the art VA medical center in west Portland. The Administrator is a person some describe as one of the nation's best administrators, Barry Bell. Mr. Bell works with an excellent support staff, a member of which is here today and will testify before this committee.

But what happens when a state of the art VA hospital pulls up with a $2.2 million shortfall?

- the staffing ratio soars to 1 nurse for every 10 patients. Forget quality care; under these conditions, even the best nurse cannot provide safe care.

- nursing home contracts are a thing of the past. In July, non service connected patients have had their contracts terminated with two week notices.

- Up to 80 beds in Portland will lay empty next year because of shortfalls. That means more vets in waiting rooms ... vets sent home early to make bed-space.

- Morale of the professional staff is terrible. The testimony you are about to hear from a dedicated highly professional nursing supervisor is hair raising. VA staff has been instructed to cut nursing home contracts, personnel, prescriptions, and travel expenses. And to make matters worse, all indications show that next year will be even worse with greater shortfalls and deeper cuts.

There is no justification for turning away veterans' at the front door of their medical centers. There is no justification for delaying attention to needy veterans -- like one of whom, in my district, carries shrapnel in his body and is told to exercise and learn to endure pain.

As we begin to solve the budget crises in the wake of the Reagan years, we face some very hard decisions. But in my book, the question of whether or not veterans will be shortchanged is not a very difficult question. We made a committment to those that served. And now is the time to make good on our promises.

TESTIMONY

CONGRESSMAN RON WYDEN

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

SEPTEMBER 7, 1988

Mr. Chairman, I appreciate the opportunity to come before this distinguished committee to share with you serious revelations that have come to my attention regarding the quality of health care for our nation's veterans.

Throughout my eight years in the Congress, I have focused my energies on improving access to affordable, quality health care for all Americans. I also have been proud to work with many members of this committee to ensure that America upholds its commitment to provide quality health care to those who have put their lives on the line for this country -- this nation's veterans.

Unfortunately, budget shortfalls facing the VA medical facilities in Portland, Oregon, and other VA facilities around the country are making many veterans in need of health care feel they are once again putting their lives on the line -- just by entering these VA medical facilities.

Let me acknowledge at the outset the extreme challenge facing anyone who works in a VA medical facility. There are many older veterans with serious, acute medical conditions that are expensive to treat. From administrators to doctors to nurses and all the men and women who work at these facilities, the challenges are monumental.

However, these challenges are pushing the system to the breaking point, and it is the veteran who is being broken.

Over the past eight months, complaints to my office regarding quality of care at Portland's VA hospital have risen in number and in seriousness. Yet it is not just the patients and their families who are up in arms.

Care providers within Portland's VA hospital have contacted me expressing frustration and anger at their inability to provide quality care with staff levels that have been cut to the bone because of the budget squeeze facing the hospital. These are dedicated professionals who are making Herculean efforts to take care of our veterans, but they have told me, flat out, they can't do it under current conditions.

Allow me to provide several examples.

o Portland has a brand new VA Hospital that opened in February of this year. One whole 40-bed ward of that hospital is closed because the hospital can't afford to staff it. The result has been calls to my office from veterans reporting delays in serious -- though not life-threatening -- medical treatment.

o At the Portland VA medical center, the nurse-to-patient ratio has been cut to 1:10. At private hospitals in the Portland area, the ratio is generally 1:4. Care providers at the VA medical center have informed me that patients lie in their feces and urine for hours at a time. Medications scheduled to be delivered by 9 a.m. many times aren't administered to patients until 2 p.m.

o A nurse at the Portland VA hospital told a member of my staff of a typical day where she worked a 10-1/2 hour shift without any breaks. A patient on her ward had chest pains throughout the day and required close observation and evaluation. Because the ward was short-staffed and the one patient required nearly constant care, this nurse was forced to neglect the other 21 patients of that ward. During this time, medications were not administered and surgical dressing changes were not made.

o An instructor from the largest community college nursing school in the state no longer sends all of her student nursing rotations to the VA hospital because of poor role modeling. One recent rotation at the VA hospital witnessed an unsupervised medical student improperly perform a delicate blood circulation test. Improper administration of this test can result in permanent hand paralysis. Fortunately, in this instance, it did not.

o Veterans and the families of veterans are chosing other hospitals for medical treatment. The mother of a 100% service-connected veteran contacted my office when her son received such poor care at the Portland VA hospital that they felt forced to admit him to a private hospital and incur the $147,000 cost of saving his life. This veteran's family believes that their son is with them today because they made the difficult choice to take him out of the VA hospital and put him in a private hospital where the nurse-to-patient ratio is lower and the care providers have time to take care of a critical patient.

Two weeks ago, in response to concerns I had personally raised with the Portland VA hospital administrator regarding immediate and future VA medical service cuts, a briefing was held to review what steps will be taken to address the budget squeeze in Portland. These cuts include:

- o reductions in nursing home care
- o elimination of most ambulance payments
- o elimination of over-the-counter drugs
- o reductions in out-patient care
- o reduction in kidney dialysis treatments -- no new patients
- o staff reductions of 120 positions -- including 22 full time equivalent nursing positions.

We can already see the impact of these cuts in the real world of our veterans. Just last Friday, a constituent contacted my Portland office because he had been discharged from the VA hospital that morning, yet was suffering from a bowel blockage. Because he is a kidney dialysis patient, this condition is life-threatening, and the veteran needed to go back to the hosptial, but had no way of getting there. The VA, under the swinging hammer of this budget crunch, could not -- or would not -- pay for an ambulance to bring the veteran back to the hospital.

I am not here to assign fault to the administrator of the hospital or anyone else who works there. Many dedicated professionals in the VA are trying to do their best under circumstances that, at times, ironically appear to resemble front-line, war-time medical conditions. And in many instances, they are meeting these monolithic challenges with success, providing quality health care to veterans who deserve nothing less.

I do, however, cite these examples simply to say that what is happening in Portland, Oregon, and at VA facilities around this country is not right. It is not fair. And it is not moral. Our nation should not subject its veterans -- in their greatest hours of need -- to substandard health care -- care that at times angers and frightens patients and caregivers alike.

And substandard care for today's veterans is a message for tommorrow's generations. Young people today who see their fathers and grandfathers receive less than adequate care will think twice before devoting their lives to their country. If they think our promise to provide health care in later years is a hollow one, they may just stay away.

Mr. Chairman, I am here today because I don't want our commitment to today's veterans or tomorrow's to be hollow. Our veterans deserve better and America can do better. I look forward to working with you and the other members of this committee to take the necessary steps to make sure all of America's veterans have access to quality health care all the time.

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SEP 7 '88 9:05 WYDEN DIST OFFICE PAGE.02

Medical Center

Portland Division
3710 Southwest U.S
Veterans Hospital Road
P O Box 1034
Portland OR 97207

Veterans Administration

RECEIVED
SEP 1 1988
Hon. Ron Wyden

AUG 30 1988

In Reply Refer To
[redacted]

Honorable Ron Wyden
Member, United States House
Representatives
District Office
P. O. Box 3621
Portland, OR 97208

Dear Mr. Wyden:

This is in response to your inquiry on behalf of Mr. [redacted], who has complained of a very long wait for an appointment in our neurosurgery clinic. I can certainly understand Mr. [redacted] dismay at a four-hour wait and I am sorry that he had such an uncomfortable experience.

Our neurosurgery clinic is presently understaffed. On the day of Mr. [redacted]s visit, there was one physician available in the clinic and approximately 38 patients to be seen. New patients often take up to an hour for evaluation and quite often an emergency in our admitting office calls the physican away from clinic. I regret that Mr. [redacted] and other patients were asked to wait so long and wish to offer my apologies.

Thank you for your interest and concern.

Sincerely,

BARRY L. BELL
Medical Center Director

TESTIMONY BEFORE SUBCOMMITTEE ON HOSPITAL

AND HEALTH CARE, VETERANS AFFAIRS COMMITTEE

CONGRESSMAN JIM OLIN

SEPTEMBER 7, 1988

THANK YOU MR. CHAIRMAN. I APPRECIATE THE OPPORTUNITY TO TESTIFY BEFORE YOUR COMMITTEE.

I HAVE REPRESENTED THE 6TH DISTRICT OF VIRGINIA FOR ALMOST SIX YEARS. THIS DISTRICT INCLUDES THE LARGE VA MEDICAL CENTER LOCATED IN SALEM, VIRGINIA. OVER THE YEARS, SINCE IT WAS DEDICATED BY PRESIDENT ROOSEVELT IN 1934, IT HAS SERVED VETERANS IN THE LARGE AREA OF SOUTHWEST VIRGINIA IN AN OUTSTANDING FASHION.

JUST THIS YEAR, I HAD THE HONOR OF PARTICIPATING IN THE GROUND BREAKING OF A $66 MILLION NEW ADDITION WHICH WILL PERMIT CONSOLIDATION OF A NUMBER OF HOSPITAL FUNCTIONS TO MAKE POSSIBLE A HIGHER QUALITY OF MEDICAL CARE AND AN IMPROVEMENT IN EFFICIENCY. THE DECISION TO MAKE THIS INVESTMENT, THE FIRST SINCE THE HOSPITAL WAS BUILT, ATTESTS TO THE QUALITY OF THE SERVICE BEING RENDERED BY THIS FACILITY.

I AM APPEARING BEFORE YOU TODAY BECAUSE FOR THE PAST TWO YEARS EMPLOYEES AT THE HOSPITAL HAVE INFORMED ME OF WHAT APPEARS TO BE OUTSIDE MANAGEMENT PRESSURE TO REDUCE FUNDING AND PERSONNEL LEVELS FOR CLINICAL ACTIVITIES THAT IS SHORTLY GOING TO REDUCE QUALITY HEALTH CARE TO VETERANS.

IN THE FACE OF AN INCREASE IN PATIENT LOAD SINCE 1983 OF 15% IN OUTPATIENT VISITS AND 7% IN INPATIENT POPULATION, THE HOSPITAL HAS BEEN REQUIRED TO MAKE A 6% REDUCTION IN DIRECT CLINICAL EMPLOYEES. THIS TREND SHOWS ON THE ATTACHED CHART. UNTIL RECENTLY THE STAFF HAS BEEN ABLE TO STRETCH ITS EFFORTS TO ACCOMMODATE BUT IT IS AT THE BREAKING POINT. NOW AN ADDITIONAL REDUCTION OF 71 DIRECT CLINICAL EMPLOYEES HAS BEEN MANDATED. THIS IS AN ADDITIONAL 5% REDUCTION. AS A RESULT, THE HOSPITAL DIRECTOR PLANS TO TERMINATE TWO 40 BED WARDS PRESENTLY SERVING 70 PSYCHIATRIC AND LONG TERM MEDICAL VETERANS PATIENTS. MANY OF THOSE MEN WILL HAVE TO BE MOVED OUT. IT WILL BE VERY DIFFICULT TO FIND SUITABLE LONG TERM CARE FOR THEM IN THE COMMUNITY.

IT WAS MY UNDERSTANDING IN RECENT YEARS THAT THE CONGRESS PROVIDED SUFFICIENT FUNDING FOR THE VA SO THAT IT COULD MAINTAIN THE CURRENT SERVICES -- THAT CUTBACKS IN OUR COMMITMENTS TO VETERANS WOULD NOT HAVE TO BE MADE.

THE SALEM VA MEDICAL CENTER IS A 700 BED FACILITY. IT'S ANNUAL BUDGET IS ABOUT $60 MILLION. IT IS PRESENTLY SHORT ABOUT 100 EMPLOYEES FROM WHAT GOOD MEDICAL CARE REQUIRES. THE BUDGET IS ABOUT $2 MILLION SHORT OF WHAT IT NEEDS TO BE. AND NOW THIS SITUATION IS FORCING A 10% CUT IN BEDS AVAILABLE TO VETERANS AT A TIME WHEN WORLD WAR II AND KOREAN VETERANS ARE REACHING RETIREMENT AGE AND THEIR PHYSICAL INFIRMITIES ARE INCREASING.

I DON'T THINK THIS IS KEEPING OUR COMMITMENT TO VETERANS -- NOR SHOULD IT BE NECESSARY.

I AM TOLD THAT PART OF THE PROBLEM AT THE SALEM MEDICAL CENTER IS THE APPLICATION OF THE RAM SYSTEM OF MEASUREMENT, THE "RESOURCE ALLOCATION METHODOLOGY." THIS IS A TYPE OF DRG SYSTEM APPLIED ACROSS THE VA SYSTEM. PEOPLE AT SALEM FEEL THAT THE RAM SYSTEM DOES NOT MAKE PROPER ALLOWANCE FOR THE CAMPUS TYPE FACILITY THAT IT IS, OR THE FACT THAT IT IS A CENTER IN THE EASTERN REGION FOR PSYCHIATRIC PATIENTS. IT GETS MOST OF THE LONG TERM CASES AFTER ACUTE CARE IS GIVEN AT FOUR OTHER VA HOSPITALS IN VIRGINIA AND WEST VIRGINIA. THE SALEM HOSPITAL TRIES TO HELP THESE PATIENTS TO REHABILITATE THEMSELVES SO THAT THEY WILL NOT HAVE TO SPEND THE REST OF THE THEIR LIVES IN THE HOSPITAL. THIS TAKES TRAINED STAFF IN THE PROPER NUMBERS OR THE REMEDIAL WORK CANNOT BE DONE. IF THE RAM SYSTEM CONTINUES TO BE APPLIED AS AT PRESENT, THIS FINE HOSPITAL THAT HAS A

REPUTATION FOR MOVING DIFFICULT CASES THROUGH THE HOSPITAL SUCCESSFULLY WILL HAVE TO SHUT DOWN THIS WORK AND REVERT TO A NURSING HOME STATUS.

THE EMPLOYEES AT THE SALEM VA MEDICAL CENTER DO NOT LIKE WHAT THEY SEE HAPPENING AND NEITHER DO I. A WAY HAS GOT TO BE FOUND TO PUT A STOP TO THE REMOVAL OF 71 MORE CRITICAL STAFF PEOPLE. $2 MILLION OF BUDGET FUNDS NEEDS TO BE RESTORED. THEN A STUDY NEEDS TO BE MADE ON WHETHER PREVIOUS ARBITRARY CUTS SHOULD BE RESTORED.

IT IS RIDICULOUS TO START SHUTTING THIS HOSPITAL DOWN RIGHT AT THE TIME WE ARE SPENDING $66 MILLION TO MODERNIZE IT. AND IT IS CONTRARY TO OUR COMMITMENT TO VETERANS TO CUT BACK ON THE CURRENT LEVEL OF SERVICES.

I REQUEST THIS COMMITTEE TO DO WHAT IT CAN TO BRING ABOUT A CORRECTION OF THIS SITUATION THAT EXISTS AT SALEM AND NO DOUBT ALSO EXISTS IN A NUMBER OF OTHER VA MEDICAL FACILITIES IN OTHER STATES.

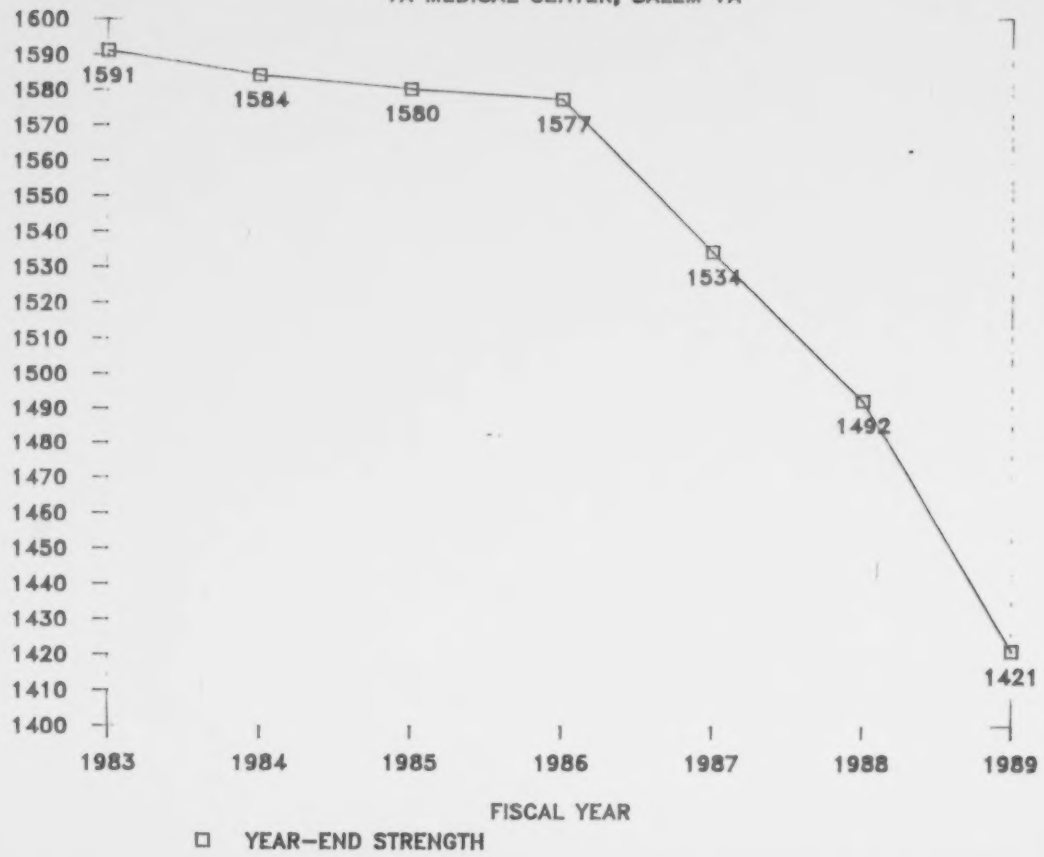
THANK YOU.

STAFFING/WORKLOAD DATA

VA MEDICAL CENTER, SALEM VA

WORKLOAD SPECIFICS

OUTPATIENT VISITS	INPATIENT VISITS
127,904	7,793
129,898	7,615
133,468	7,834
141,562	8,197
147,154	8,485
148,000	8,313



Subcomm. on Hospitals and Health Care
Montgomery, Chmn.

Statement By
W. G. (Bill) Hefner
Before the Veterans' Affairs Committee
September 7, 1988

Mr. Chairman, I'm pleased to introduce to the Committee my good friend Mr. Thomas L. Ayres, the Director and Chief Executive Officer of the Veterans' Administration Medical Center in my Congressional District. We are proud of our hospital in Salisbury and of the good work that Tom and his staff does there.

Tom has been at the Salisbury hospital since September of 1981.

Since 1959 Tom has served the Veterans' Administration in various capacities at six Medical Centers throughout the U.S.

Prior to coming to Salisbury, he served at the VA Central Office here in Washington as Executive Assistant to the Associate Deputy Chief Medical Director.

Tom served in our armed forces as a medical corpsman in the U.S. Army, 1956-1959.

In addition to his duties as director of the 904 bed Salisbury facility, he is responsible for the V.A. Outpatient Clinic located in Winston-Salem, the clinic of jurisdiction for the State of North Carolina Outpatient program. This responsibility includes services to 5,600 inpatients and 78,000 outpatients annually.

For his work on behalf of veterans, he has received numerous service awards from veterans' groups, including the DAV and VFW. He is a committed and capable man. Submit other curriculum for

And so, it is with pleasure that I introduce Mr. Ayres to the Committee.

#

Around 2:00

90-284 0 - 88 - 5

CURRICULUM VITAE

Thomas L. Ayres

Date of Birth:	October 29, 1936
Place of Birth:	Red Key, Indiana
Marital Status:	Married to Christa Ayres Three grown children
Home Address:	709 Candlewick Drive Salisbury, North Carolina 28144
Education:	Health Care Studies, University of Indiana Health Care Studies, University of Wisconsin 1981 Graduate of VA Leadership Program
Experience:	September 1981 - Present Director, Chief Executive Officer, Veterans Administration Medical Center, Salisbury, North Carolina. Facility consists of 811 hospital beds and 93 nursing home beds. Additionally responsible for the VA Outpatient Clinic located in Winston-Salem, North Carolina which serves as the clinic of jurisdiction for the State of North Carolina Outpatient Program. This responsibility includes service to approximately 5,600 inpatients and 78,000 outpatients annually with 1,300 employees and an annual operating budget in excess of $59 million. July 1979 - September 1981 Executive Assistant to the Associate Deputy Chief Medical Director, VA Central Office, Washington, DC. Provided administrative assistance within six regional medical districts in the areas of planning, budgeting, management and communications for 172 medical centers in the United States, with a department budget of 6 billion dollars annually. June 1959 - July 1979 Served at six VA Medical Centers in Indiana, Ohio, Florida, New Hampshire and Wisconsin in progressively responsible positions; i.e., Assistant Director; Administrative Assistant/ Chief of Staff; Chief, Voluntary Service; Recreation Therapist and Nursing Assistant.

Military Service: U.S. Army - August 1956 - January 1959
Berlin, Germany
Medical Corpsman, Air Evacuation Section

Community Activities:
Member First United Methodist Church
Past President Rowan Veterans Council
Advisor to N. C. Veterans Council
32nd Degree Mason
Member Board of Directors of Salisbury-Rowan Chamber of Commerce
Member of NC State Coordinating Council appointed by Governor of NC
Member of Salisbury Zoning Board
First VA Medical Center Executive to Chair a United Way Drive and also to be a President of the local United Way
Member Board of Directors of the United Way for a 4-year term
Past member of the USS North Carolina Battleship Commission appointed by the Governor of North Carolina

Recent Awards:
VA Administrator's Commendation for public service in the community
National DAV Commander Award for service to veterans
VFW Award for outstanding and distinguished service to veterans
Rowan Veterans Council Appreciation Award for service to veterans
United Way Service Award for serving as President of the 1986 campaign
United Way Award for chairing the 1985 campaign
Superior Performance Awards 1976, 1985, 1986
Executive Performance Awards 1985, 1986, 1987

Veterans Administration

STATEMENT

OF THE

HONORABLE THOMAS K. TURNAGE

ADMINISTRATOR OF VETERANS' AFFAIRS

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

SEPTEMBER 7, 1988

Mr. Chairman and Members of the Committee:

It is a pleasure to appear before you to discuss the funding status of the VA Medical Program in Fiscal Year 1988.

Mr. Chairman, there has been a great deal of concern raised from congressional sources about the adequacy of funding of the VA health care program. As was discussed earlier this year during budget hearings, the level of expenditures for FY 88 has been controlled closely because of the "bipartisan budget agreement" entered into by the Congress and the Administration as a means of reducing the level of deficit spending. VA medical care was treated more generously than other discretionary programs across the government as the Fiscal Year 1988 pay increase was fully funded for VA medical care, while other agencies absorbed some or all of the increase. In addition, the President just signed the Emergency Supplemental in which Congress voted to appropriate $31 million for medical care without providing offsets in discretionary spending.

Our operating flexibility has continued to be limited in FY 1988 by Congressionally mandated limits in law such as requirements to operate a minimum number of beds, maintain a specified employment level, and expend a designated amount for personal services.

There is no doubt that this funding environment presents challenges for the VA health care system, however, the system is not on the brink of collapse as has been suggested in some accounts. The VA health care system has a history of facing challenges and overcoming adversity, of management innovation and improved productivity, and of delivering quality services. The VA health care system is a dynamic enterprise that is constantly facing changing demands, creating new programs, discontinuing old programs, developing and implementing new technologies, and achieving greater efficiencies in service delivery.

We in fact monitor very closely the primary indicators of the system with monthly reports that I would like to share with you. Public Law 99-576 established a priority system for the delivery of health care to veterans and established Categories of veterans to which the VA "shall" provide care and categories to which the VA "may" provide care depending on the availability of resources. As a result of that law, we instituted a system to account for every veteran who applied for care (see attached tables 1 and 2). The reports from that system, which I would like to have included in the record, indicate that we have not turned away any veteran who applied for care whom VA has an obligation to treat. Additionally, those veterans in the "may" categories who needed care and agreed to make the copayment required by law were also provided quality medical care consistent with their needs.

Each month we monitor selected activities in the medical system to identify trends and attempt to anticipate problems from the system level (see attached charts 1 thru 15). These charts, which I also request be included in the record, reflect the applications, average daily census, occupancy rate and level of outpatient activity within the system. The charts show that there have not been any drastic changes in the level of activity during FY 1988. In fact, based on my visits to over 50 VA medical centers and my visits with the management of all VA health care facilities during recent internal budget conferences, I am convinced that the system will meet the challenges that we face and that all veterans to whom we have an obligation to provide VA health care will receive it in FY 1988.

While we have managed with narrow resource margins Dr. Gronvall and I have continued to stress a high commitment to assuring that services provided are of the highest quality possible. Our dedicated staff in the field share this commitment.

Dr. Gronvall and his staff have extensively reviewed the financial and operational condition of the VA health care system and with your approval I would ask Dr. Gronvall to present his assessment at this time.

TABLE 1

MEDICAL ADMINISTRATION SERVICE 8Z11

VETERAN ELIGIBILITY AND THE FURNISHING OF HEALTH CARE

FOR MONTH ENDING JUL 31, 1988

TOTAL ALL STATIONS

	VETERAN ELIGIBILITY	NUMBER OF APPLI-CATIONS A	---CARE RECEIVED/SCHEDULED--- HOSP. B	NURS-ING HOME CARE C	DOM. D	OUTPAT CARE E	MEDICALLY EXAMINED-NO FURTHER CARE REQ F	CAN-CELED G	NOT ELI-GI-BLE H	TREAT-MENT MODAL-ITY NOT AVAIL I	REF TO OTH-ER FAC J	PEND-ING EOM K	NOT A-GREE ING TO DE DUCT L	ITEM A AS % OF GRAND TOTAL M	OUT OF BAL N
	CATEGORY A														
01	100% SERVICE CONNECTED	14,269	3,887	45	10	9,470	283	386	29	7	147	119		6.03	3
02	90% SERVICE CONNECTED	526	88	1	2	406	16	6	5	.	2	5		.22	
03	80% SERVICE CONNECTED	1,548	302	5		1,148	24	44	9		16	24		.65	
04	70% SERVICE CONNECTED	3,393	828	16	6	2,311	77	83	25	2	42	63		1.43	
05	60% SERVICE CONNECTED	5,258	1,091	11	9	3,802	108	98	37	2	52	23		2.22	48
06	50% SERVICE CONNECTED	5,600	1,306	9	83	3,882	120	163	17	5	21	32		2.37	
07	TOTAL 50% THRU 100% S C	30,594	7,502	87	110	21,019	628	780	122	16	280	266		12.93	51
08	40% SERVICE CONNECTED	5,869	1,147	14	12	4,421	106	134	15	5	17	18		2.48	
09	30% SERVICE CONNECTED	9,822	2,067	14	17	7,241	174	224	44	12	32	37		4.15	8-
10	20% SERVICE CONNECTED	8,554	1,553	15	18	6,575	148	207	39	12	28	36		3.61	53-
11	10% SERVICE CONNECTED	18,640	3,566	29	40	14,060	349	467	64	18	48	35		7.88	4
12	0% SERVICE CONNECTED	16,467	3,806	41	62	11,764	320	362	60	20	37	22		6.96	1-
13	OTHER SERVICE CONNECTED	1,479	171	2	1	1,196	35	67	21	4	13			.62	29-
14	TOTAL 0% - 40% & OTH S C	60,831	12,310	115	150	45,257	1,132	1,461	243	71	175	148		25.70	87-
15	TOTAL (ITEMS 7 & 14)	91,435	19,812	202	260	66,276	1,760	2,241	365	87	455	414		38.63	36-
16	FORMER PRISONER OF WAR	696	104	10	1	556	15	22	4	1	3	3		.29	20-
17	AGENT ORANGE/IONIZING RAD	6,502	1,528	3	58	4,548	120	185	10	19	24	5		2.75	9
18	WORLD WAR I	1,416	495	23	1	794	55	28	13	1	8	3		.60	1
19	VA PENSIONER	24,052	7,587	90	43	15,197	439	515	82	39	62	26		10.16	1
20	MEDICAID	1,702	482	3	3	1,111	31	57	5	1	8	3		.72	
21	OTHER NSC CATEGORY A	95,604	22,601	208	321	66,835	2,316	2,578	422	154	278	118		40.40	98-
22	TOTAL (ITEMS 16 THRU 21)	129,972	32,797	337	427	89,041	2,976	3,385	536	215	383	158		54.92	107-
23	CATEGORY A TOTAL (ITEMS 15 & 22)	221,397	52,609	539	687	155,317	4,736	5,626	901	302	838	572		93.55	143-
24	CATEGORY B OTHER NSC	8,490	1,788	21	3	6,251	206	171	9	22	17	10		3.59	
25	CATEGORY C OTHER NSC	6,766	1,311	22	2	4,958	186	209	13	21	12	5	30	2.86	1
26	TOTAL CATEGORIES A, B, C	236,653	55,708	582	692	166,526	5,128	6,006	923	345	867	587	30	100.00	142-
27	ALL NON-VETERAN APPLICANTS	2,593												1.10	
28	GRAND TOTAL	239,246	55,708	582	692	166,526	5,128	6,006	923	345	867	587	30	100.00	142-
29	PERCENT OF GRAND TOTAL	100.00	23.54	.25	.29	70.37	2.17	2.54	.39	.15	.37	.25	.01		.06-

NOTE: 1. COLUMN L IS FOR CATEGORY C ONLY.
2 COLUMN N - APPLICATIONS (COLUMN A) PLUS PRIOR MONTH'S PENDING EQUALS THE SUM OF COLUMNS B THRU L - AN OUT OF BALANCE WILL OCCUR.

TABLE 2

MEDICAL ADMINISTRATION SERVICE 8ZU1
VETERAN ELIGIBILITY AND THE FURNISHING OF HEALTH CARE
FISCAL YEAR-TO-DATE THRU JUL 31, 1988

TOTAL ALL STATIONS

	VETERAN ELIGIBILITY	NUMBER OF APPLI-CATIONS A	---CARE RECEIVED/SCHEDULED--- HOSP. B	NURS-ING HOME CARE C	DOM. D	OUTPAT CARE E	MEDICALLY EXAMINED-NO FURTHER CARE REQ F	CAN-CELED G	NOT ELI-GI-BLE H	TREAT-MENT MODAL-ITY NOT AVAIL I	REF TO OTH-ER FAC J	PEND-ING EOM K	NOT A-GREE ING TO DE DUCT L	ITEM A AS % OF GRAND TOTAL M
	CATEGORY A													
01	100% SERVICE CONNECTED	142,948	40,504	501	136	92,985	4,087	3,986	171	85	710	1,143		6.01
02	90% SERVICE CONNECTED	5,341	1,160	9	11	3,901	115	102	15	1	26	44		.22
03	80% SERVICE CONNECTED	15,182	3,346	47	4	10,953	345	327	68	7	79	238		.64
04	70% SERVICE CONNECTED	33,719	8,357	71	22	23,292	818	847	144	16	151	581		1.42
05	60% SERVICE CONNECTED	51,828	11,354	83	57	37,632	1,223	998	212	20	221	220		2.18
06	50% SERVICE CONNECTED	58,162	13,060	30	207	41,277	1,562	1,487	234	44	248	345		2.44
07	TOTAL 50% THRU 100% S C	307,180	77,781	791	437	210,040	8,150	7,747	844	173	1,435	2,571		12.91
08	40% SERVICE CONNECTED	61,479	12,888	125	121	45,178	1,663	1,300	196	47	203	193		2.58
09	30% SERVICE CONNECTED	103,071	21,986	438	277	74,585	2,925	2,565	384	109	364	262		4.33
10	20% SERVICE CONNECTED	89,319	16,827	125	348	67,240	2,386	1,954	321	133	295	251		3.75
11	10% SERVICE CONNECTED	193,221	37,508	281	409	144,771	5,204	4,378	513	475	700	373		8.12
12	0% SERVICE CONNECTED	162,557	38,473	323	479	113,926	4,394	3,904	432	175	456	233		6.83
13	OTHER SERVICE CONNECTED	15,079	1,734	14	16	12,461	380	426	73	12	67	12		.63
14	TOTAL 0% - 40% & OTH S C	624,726	129,416	1,306	1,650	458,161	16,952	14,527	1,919	951	2,085	1,324		26.25
15	TOTAL (ITEMS 7 & 14)	931,906	207,197	2,097	2,087	668,201	25,102	22,274	2,763	1,124	3,520	3,895		39.15
16	FORMER PRISONER OF WAR	8,000	1,424	30	7	6,096	240	203	20	7	19	18		.34
17	AGENT ORANGE/IONIZING RAD	61,885	14,342	29	233	43,637	1,576	1,693	88	75	241	41		2.60
18	WORLD WAR I	16,024	6,222	251	18	8,756	2,384	277	128	34	34	31		.67
19	VA PENSIONER	248,670	81,360	758	480	152,690	6,552	5,098	779	326	607	247		10.45
20	MEDICAID	18,172	5,058	24	44	12,237	462	550	27	18	59	23		.76
21	OTHER NSC CATEGORY A	947,939	31,496	1,648	3,356	651,041	30,203	23,983	2,723	1,619	2,446	803		39.83
22	TOTAL (ITEMS 16 THRU 21)	1,300,690	339,902	2,740	4,138	874,457	41,417	31,804	3,765	2,079	3,406	1,163		54.65
23	CATEGORY A TOTAL (ITEMS 15 & 22)	2,232,596	547,099	4,837	6,225	1,542,658	66,519	54,078	6,528	3,203	6,926	5,058		93.80
24	CATEGORY B OTHER NSC	80,476	17,425	172	74	58,183	2,612	1,711	75	116	186	52		3.38
25	CATEGORY C OTHER NSC	67,141	14,048	264	37	47,347	2,719	2,046	118	119	124	41	291	2.82
26	TOTAL CATEGORIES A,B,C	2,380,213	578,572	5,273	6,336	1,648,188	71,850	57,835	6,721	3,438	7,236	5,151	291	100.00
27	ALL NON-VETERAN APPLICANTS	30,623												1.29
28	GRAND TOTAL	2,410,836	578,572	5,273	6,336	1,648,188	71,850	57,835	6,721	3,438	7,236	5,151	291	100.00
29	PERCENT OF GRAND TOTAL	100.00	24.31	.22	.27	69.25	3.02	2.43	.28	.14	.30	.22	.01	

*NOTE: COLUMN L IS FOR CATEGORY C ONLY.

Chart 1

APPLICATIONS FOR MEDICAL CARE CATEGORIES A, B, AND C

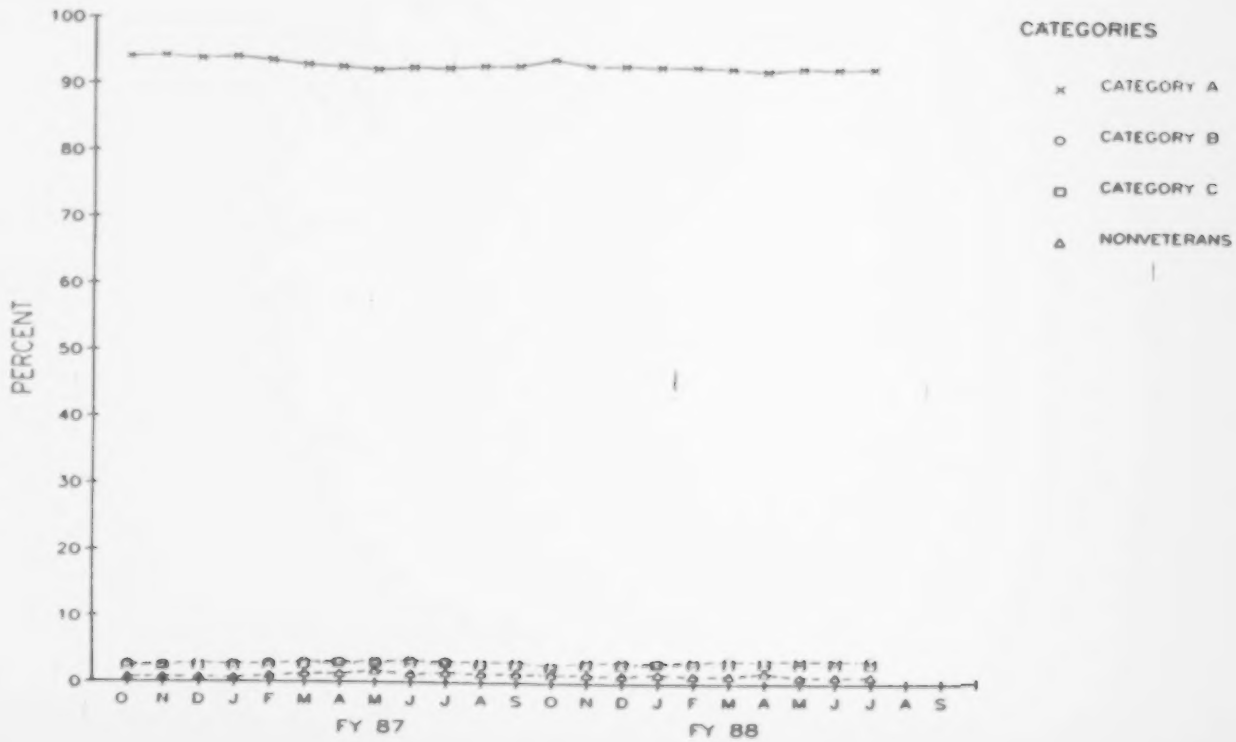


Chart 2

APPLICATIONS FOR MEDICAL CARE CATEGORY A ONLY

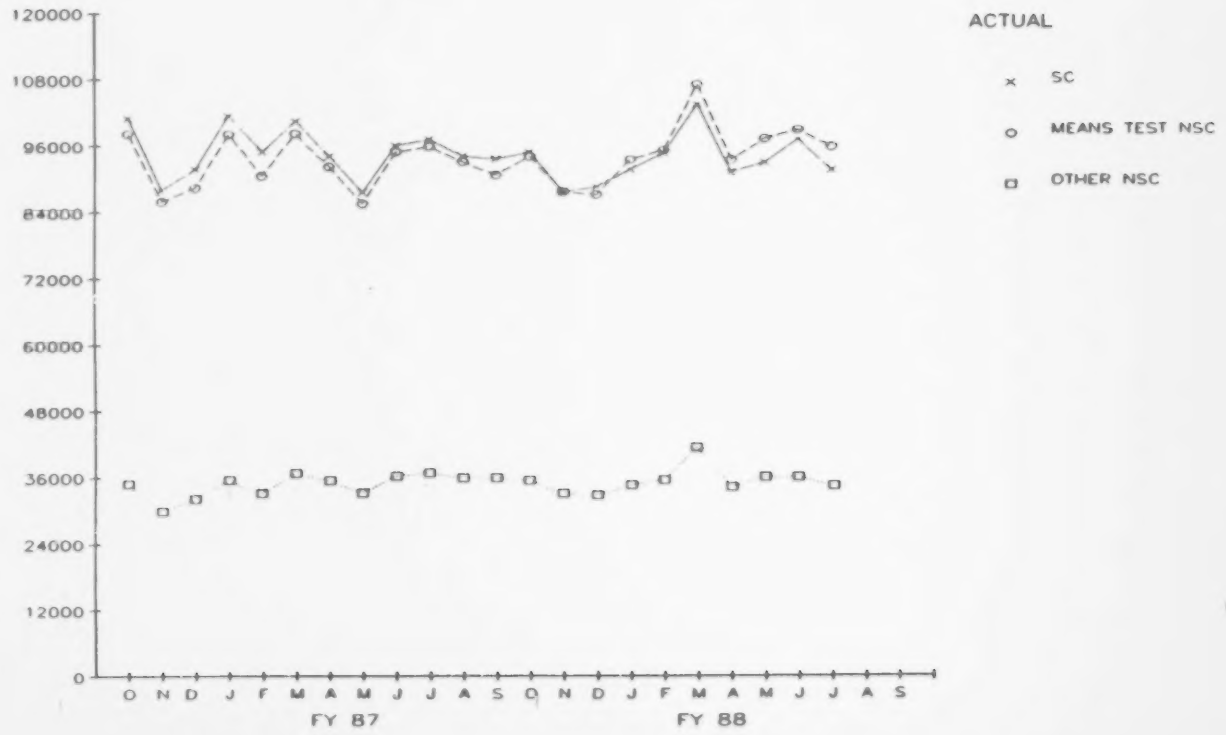


Chart 3

APPLICATIONS FOR MEDICAL CARE CATEGORIES B AND C

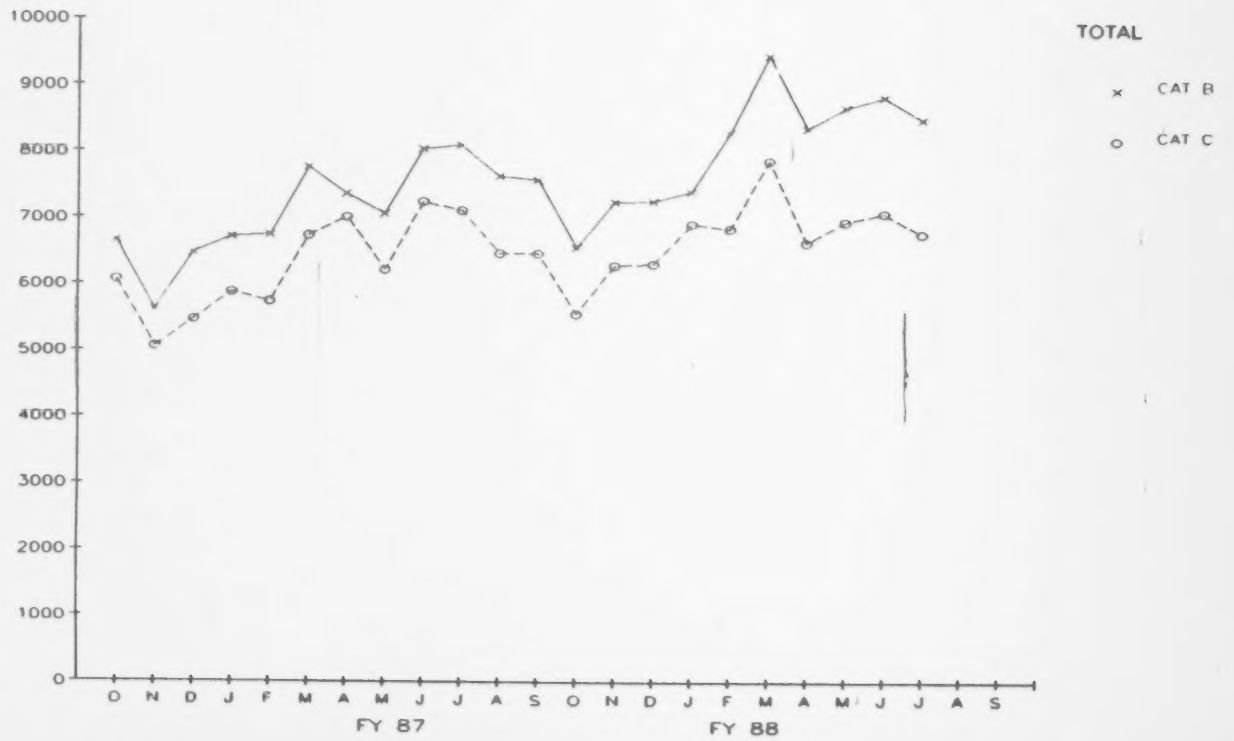


Chart 4

AVERAGE DAILY CENSUS BY BED TYPE
VA HOSPITALS

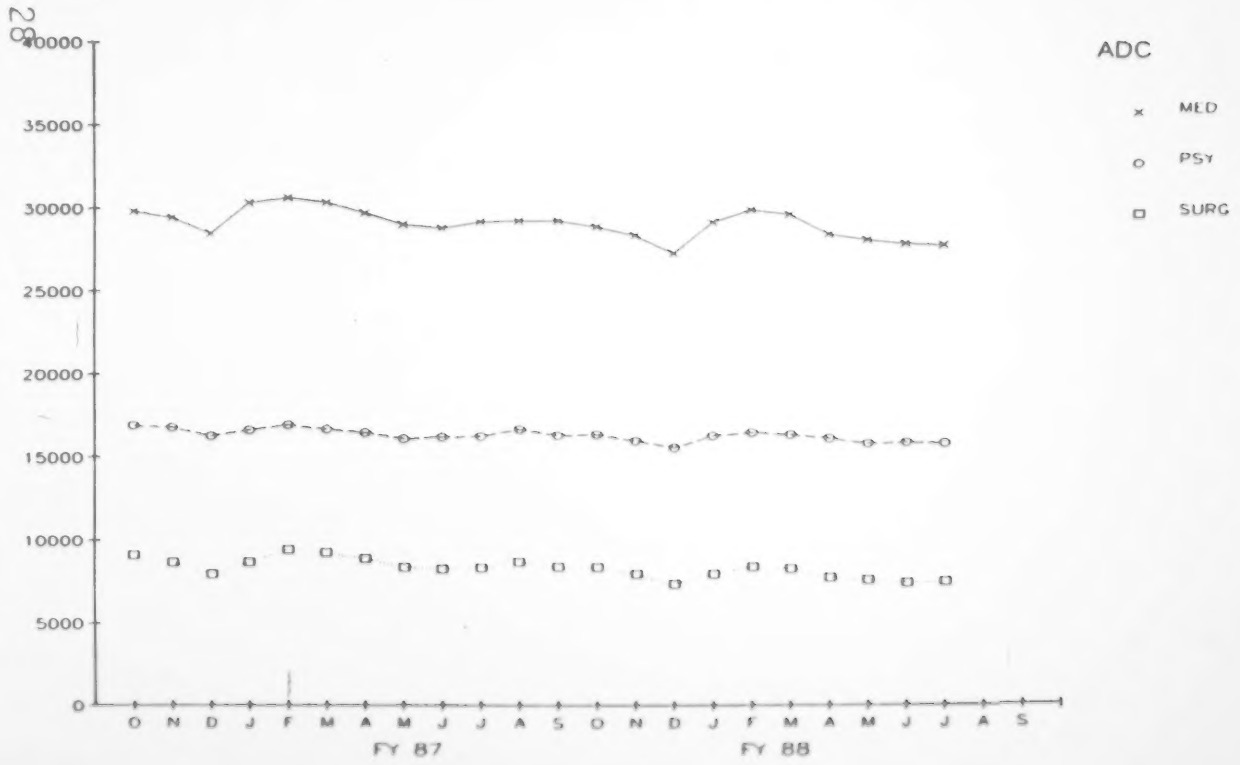


Chart 5

BED OCCUPANCY RATE BY BED TYPE
VA HOSPITALS

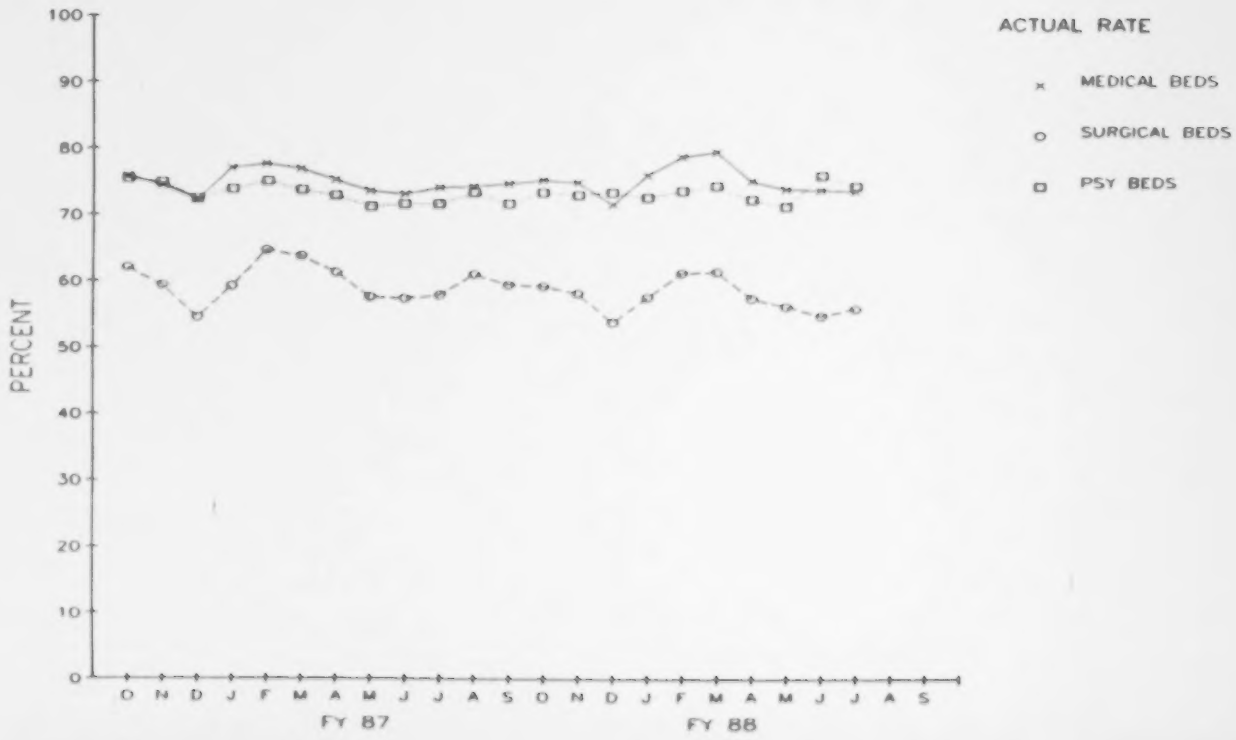


Chart 6

PATIENTS DISCHARGED BY BED TYPE
VA HOSPITALS

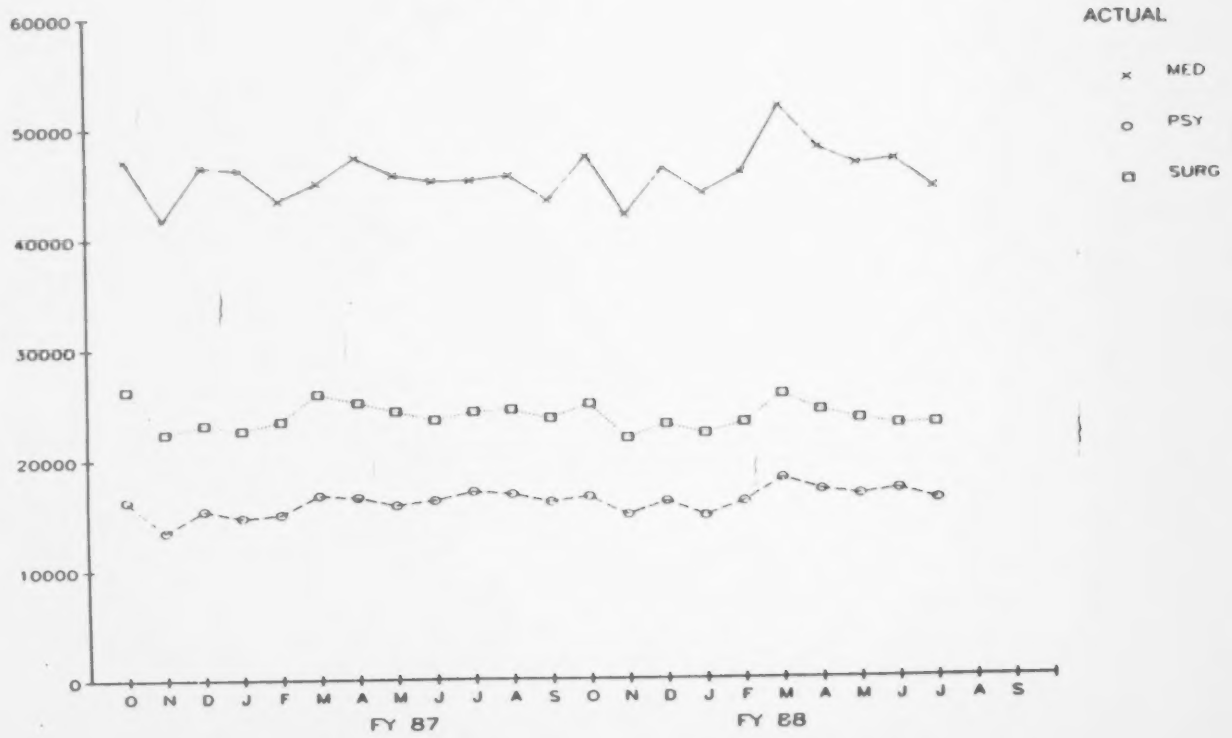


Chart 7

OPERATING BEDS BY BED TYPE
VA HOSPITALS

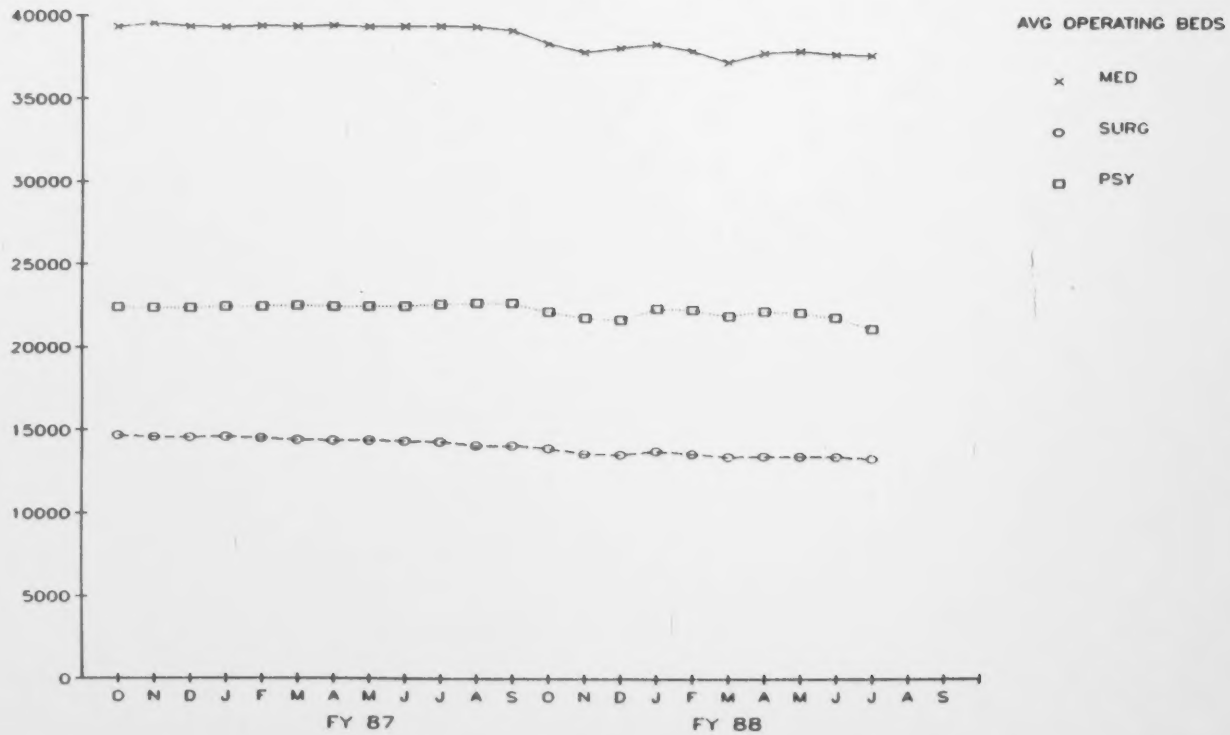


Chart 8

PATIENTS DISCHARGED NURSING HOME CARE

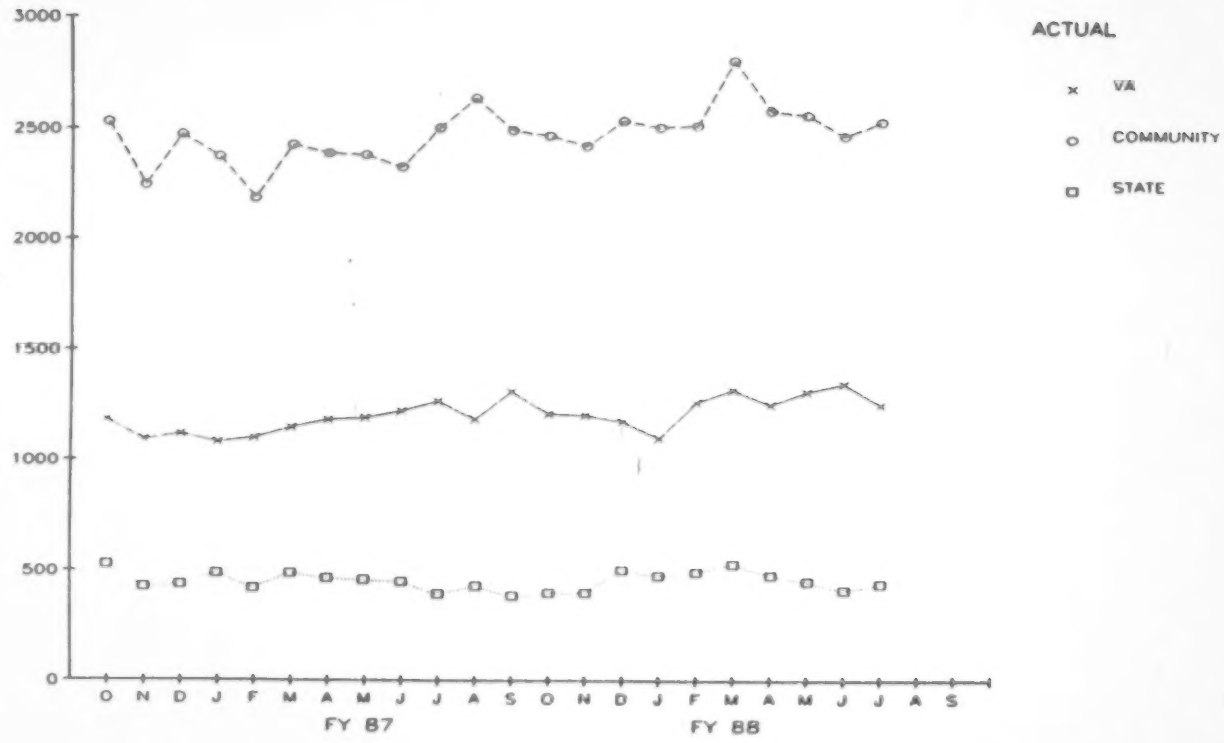


Chart 9

AVERAGE DAILY CENSUS
NURSING HOME CARE

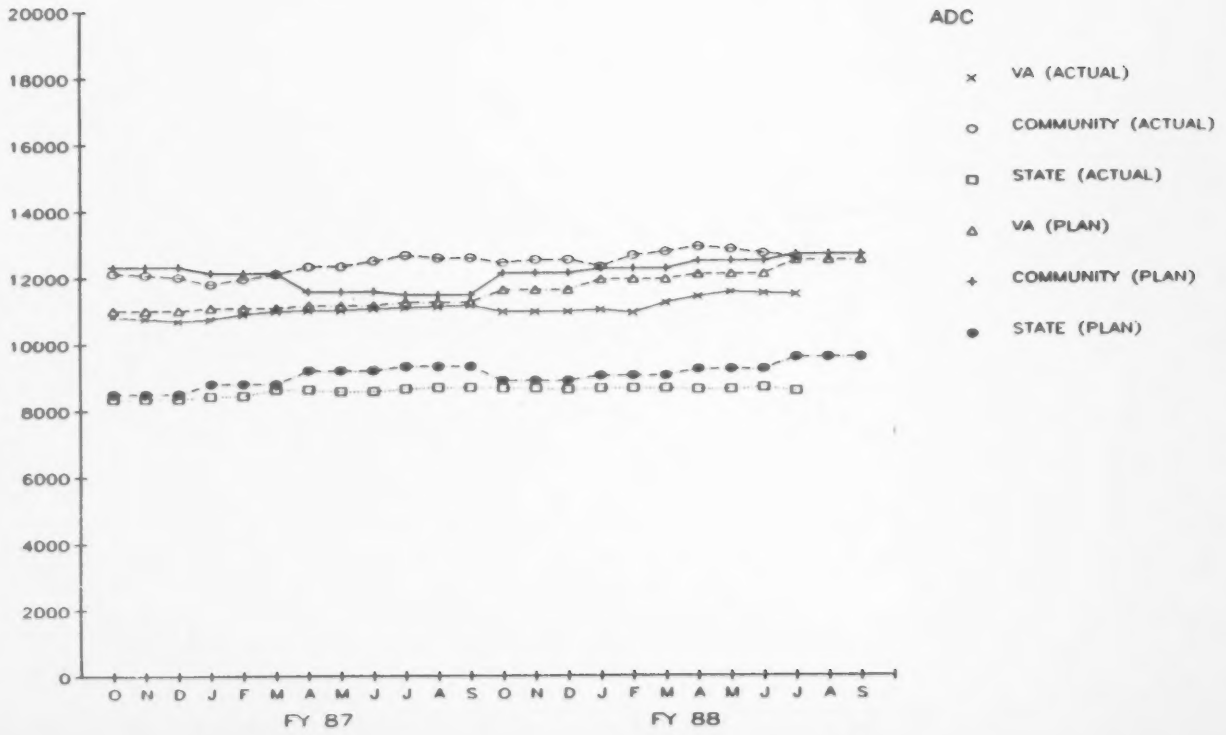


Chart 10

PATIENTS DISCHARGED DOMICILIARY CARE

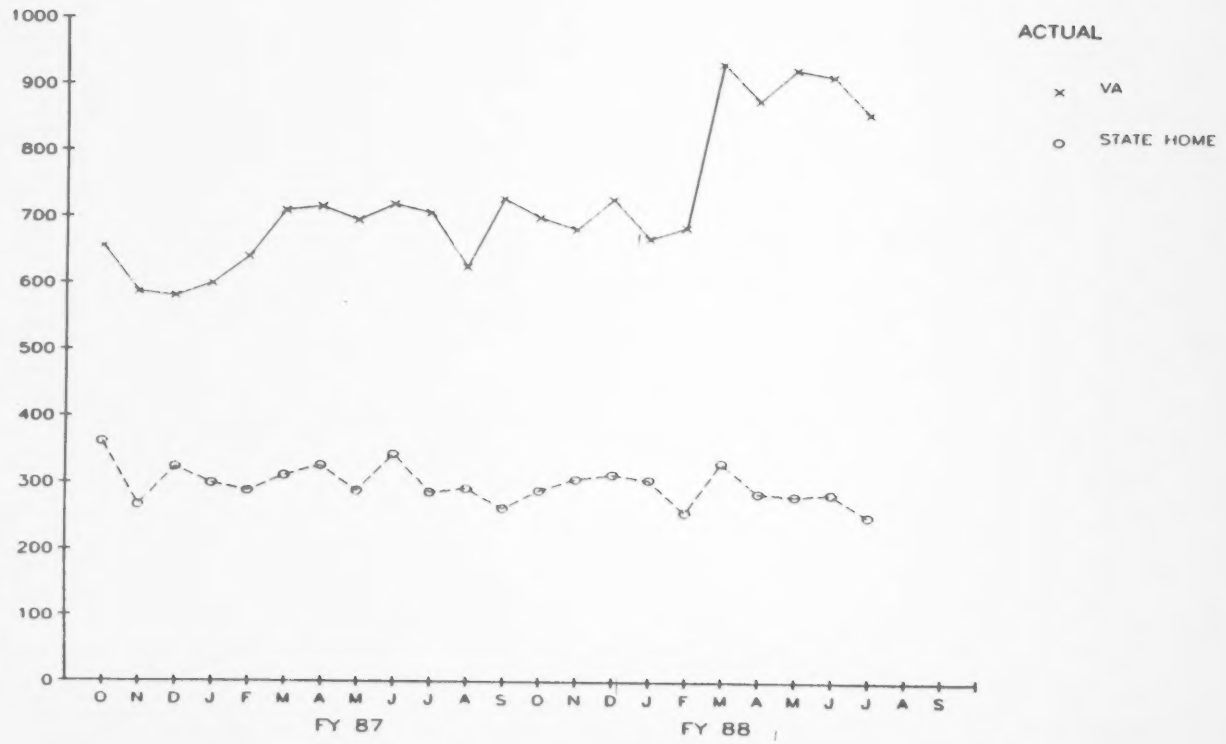


Chart 11

AVERAGE DAILY CENSUS
DOMICILIARY CARE

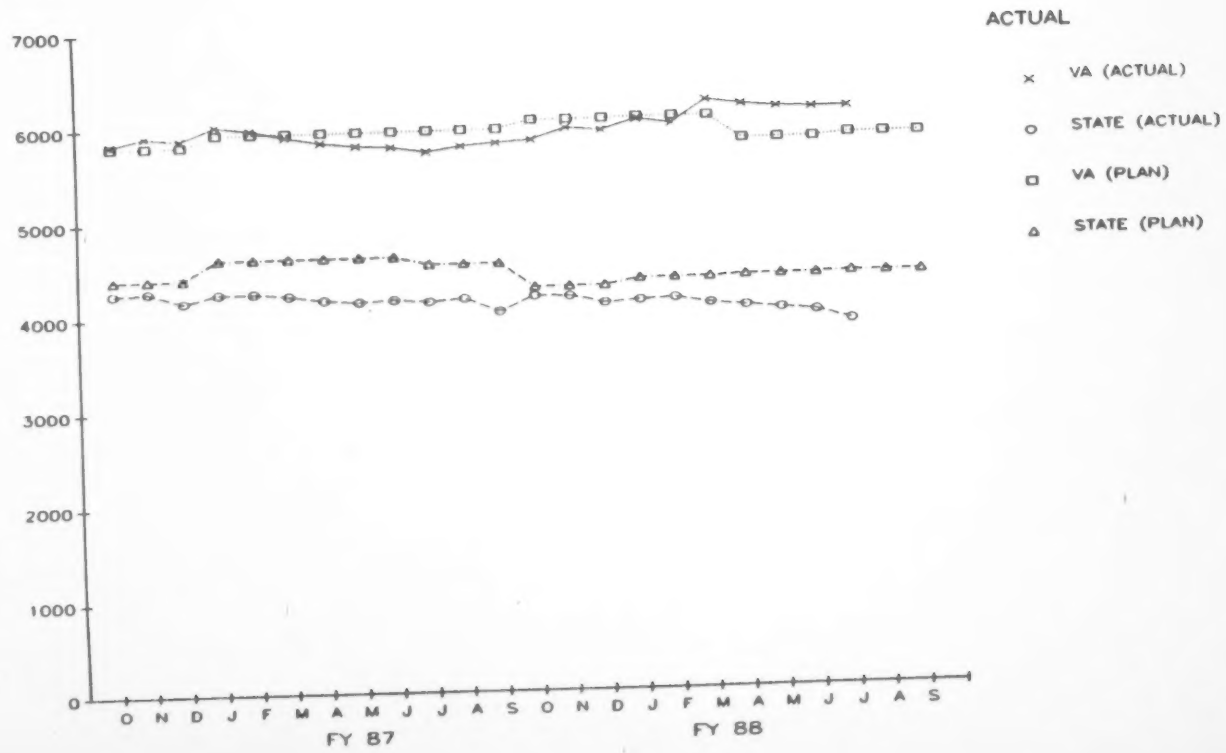


Chart 12

PATIENTS DISCHARGED NON-VA HOSPITAL CARE

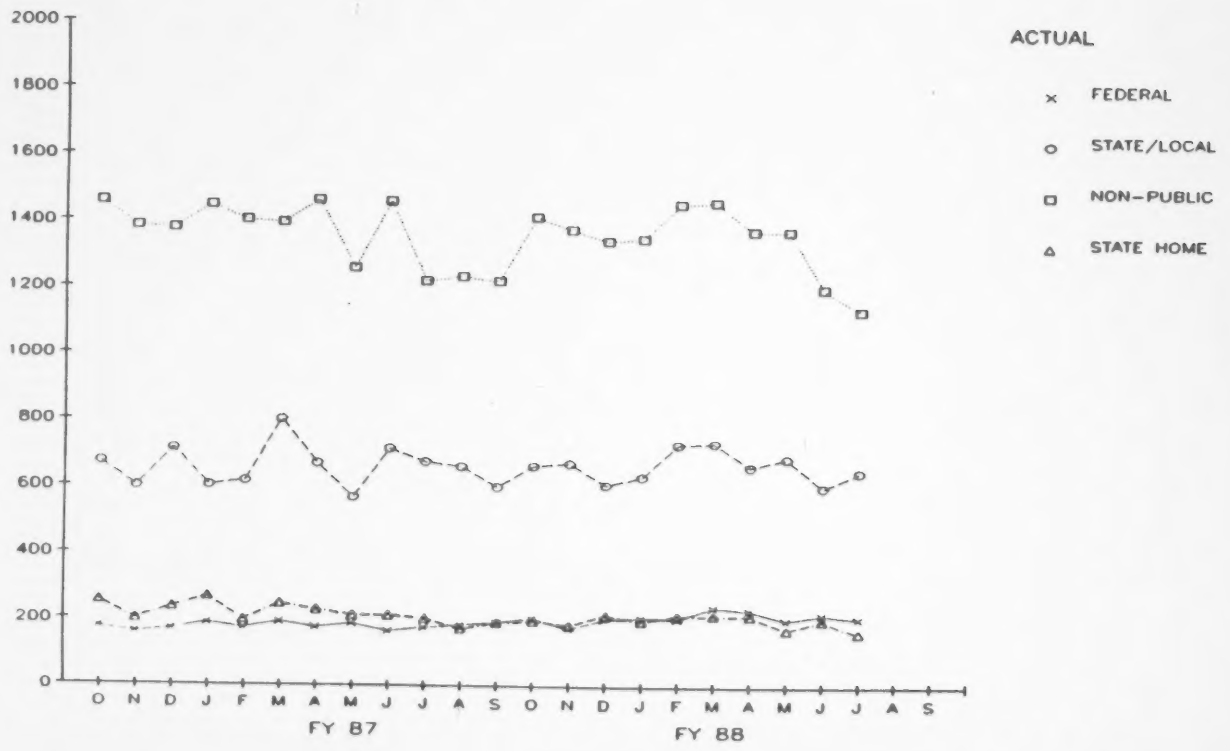


Chart 13

AVERAGE DAILY CENSUS
NON-VA HOSPITAL CARE

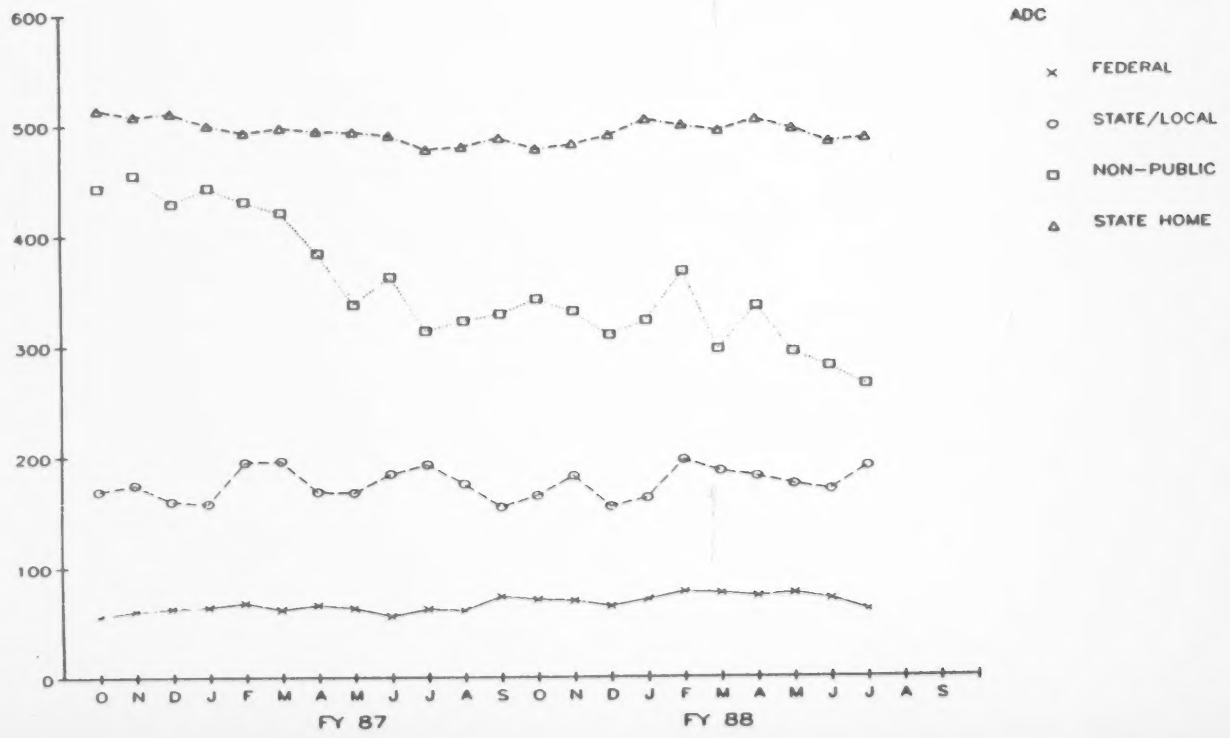


Chart 14

VISITS TO VA STAFF OUTPATIENT MEDICAL CARE

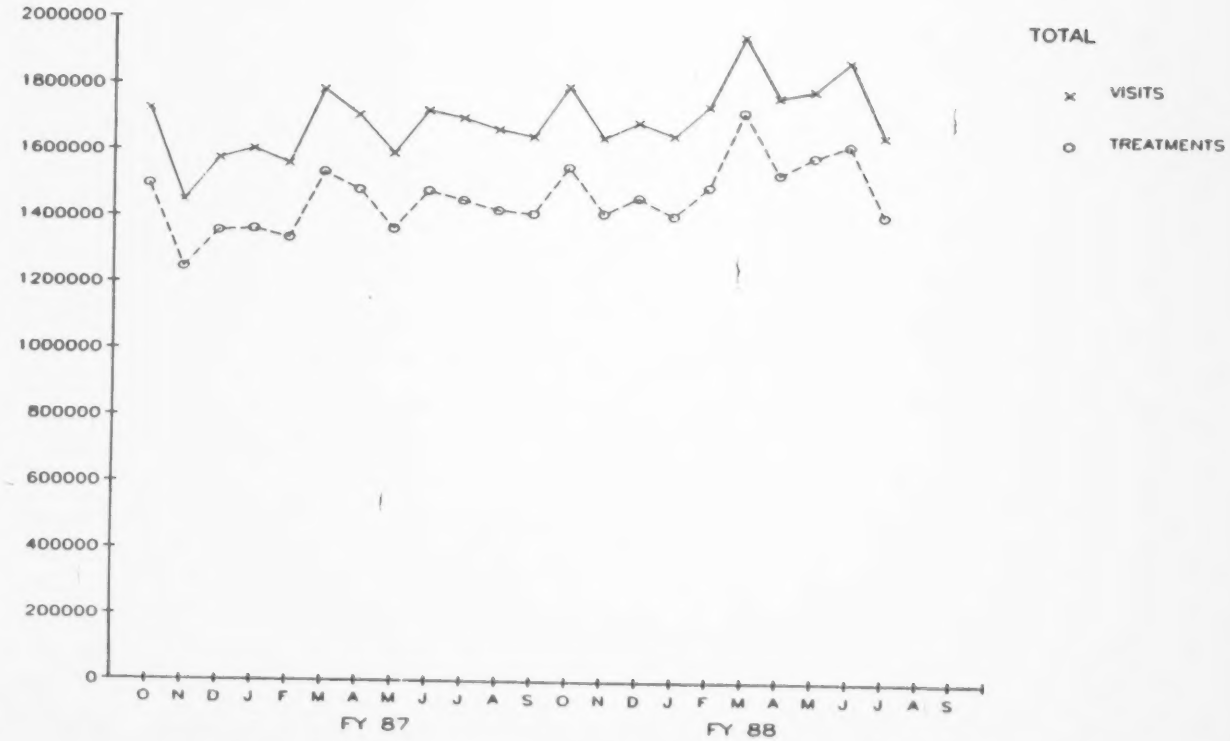
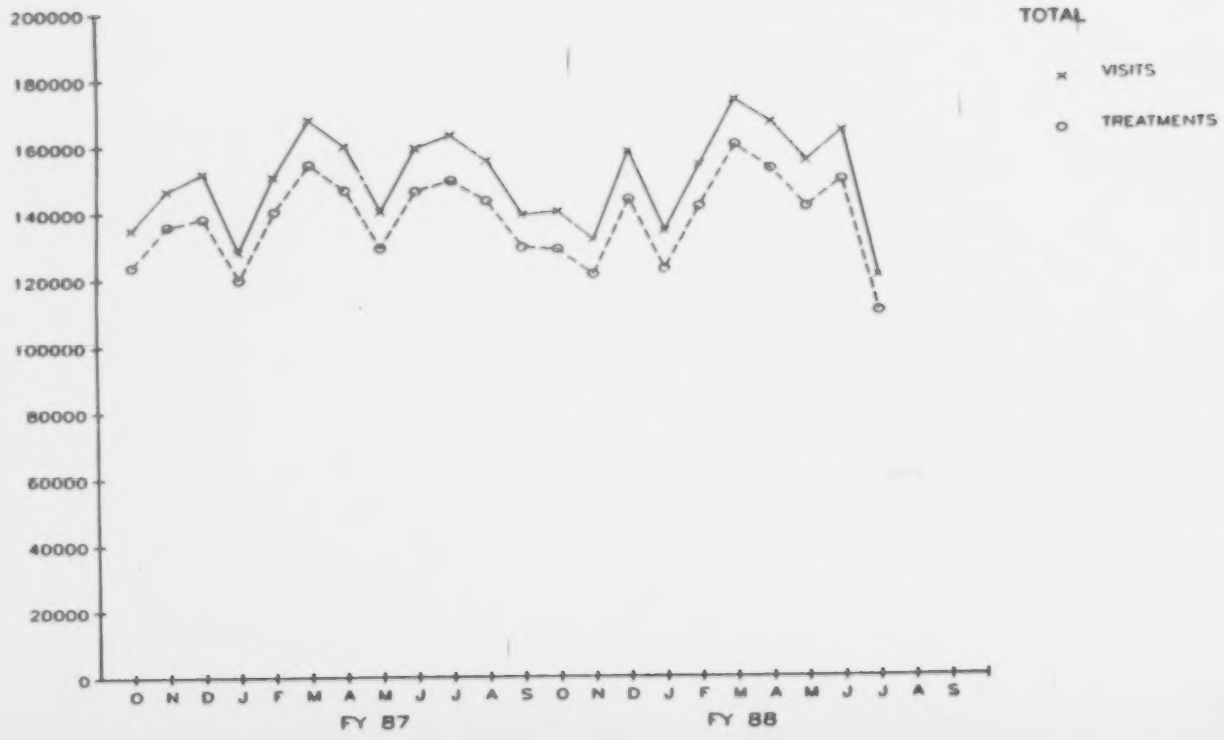


Chart 15

FEE BASIS VISITS
OUTPATIENT MEDICAL CARE



Statement of

JOHN A. GRONVALL, M.D.
CHIEF MEDICAL DIRECTOR

DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION

BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

SEPTEMBER 7, 1988

It is a pleasure to have the opportunity to appear before the Committee to expand on the statement of the Administrator regarding the status of the Department of Medicine and Surgery's programs and budget. I will summarize the recent program and budget history of the Department to create a frame of reference for understanding the current status of the Department in the final months of Fiscal Year 1988.

DECADE OF COST CONSCIOUSNESS

The past decade can accurately be characterized as a decade of cost consciousness. Not only the Veterans Administration's health care system, but the entire health industry of the United States has been primarily concerned with the escalating cost of health care and the search for mechanisms to contain costs while improving productivity. In this regard, the accomplishments of the Department of Medicine and Surgery must be viewed as a record of outstanding success.

The DM&S accomplishments are particularly apparent when the productivity record of the Department is compared to the remainder of the American hospital system. Since 1979, VA has increased the number of veterans admitted to VA hospitals and, in addition, has expanded the number of veterans admitted to VA nursing homes, domiciliaries and, on a contract basis, admissions to comparable community and state facilities. This increasing amount of institutional care, either delivered by or financed by the VA, is portrayed in Figure 1.

VA ADMISSIONS
FY 79 THROUGH FY 87

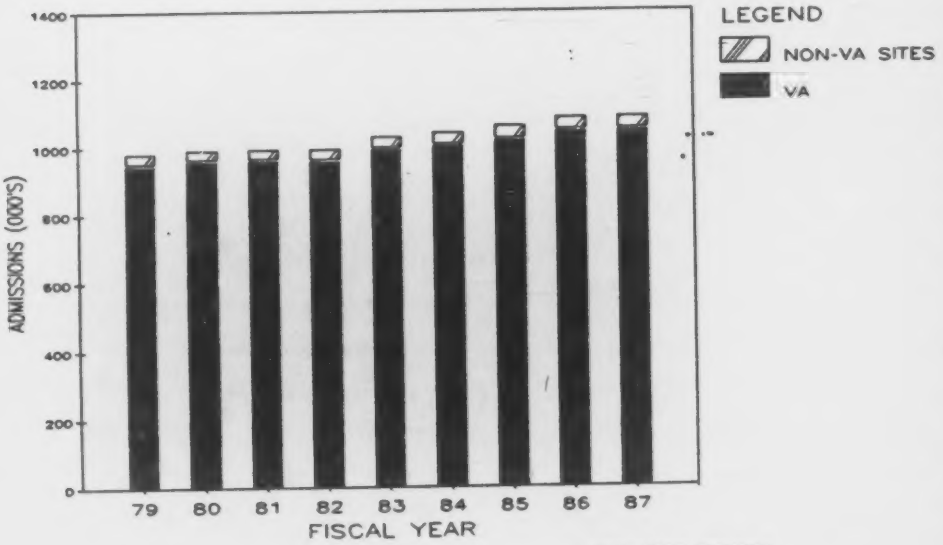


FIGURE 1

* EXCLUDES DIALYSIS

In addition, during this period VA has markedly expanded the number of outpatient visits provided. (Figure 2)

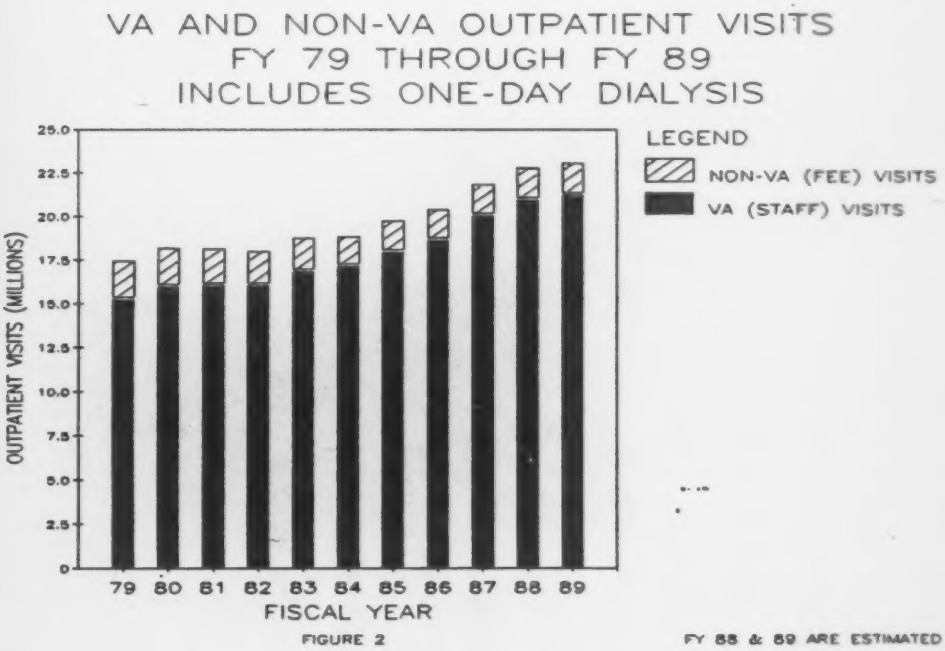


FIGURE 2

FY 88 & 89 ARE ESTIMATED

If the VA Medical Care Appropriation is viewed on an adjusted basis, taking into account federal salary increases and medical care cost inflation, the purchasing power of the appropriation during this decade has been essentially level. Thus, the VA has significantly expanded its capacity to deliver medical care on the basis of stable appropriation support.

The American Hospital Association has published data from the National Hospital Panel Survey since 1963. Therefore, data from more than 5,600 community hospitals (all non-federal, acute care hospitals, including university hospitals) can be compared to VA for this period starting in 1979. Early in the decade, community hospital admissions increased very slightly. However, since 1983, admissions to community hospitals have declined at a significant rate. (Figure 3)

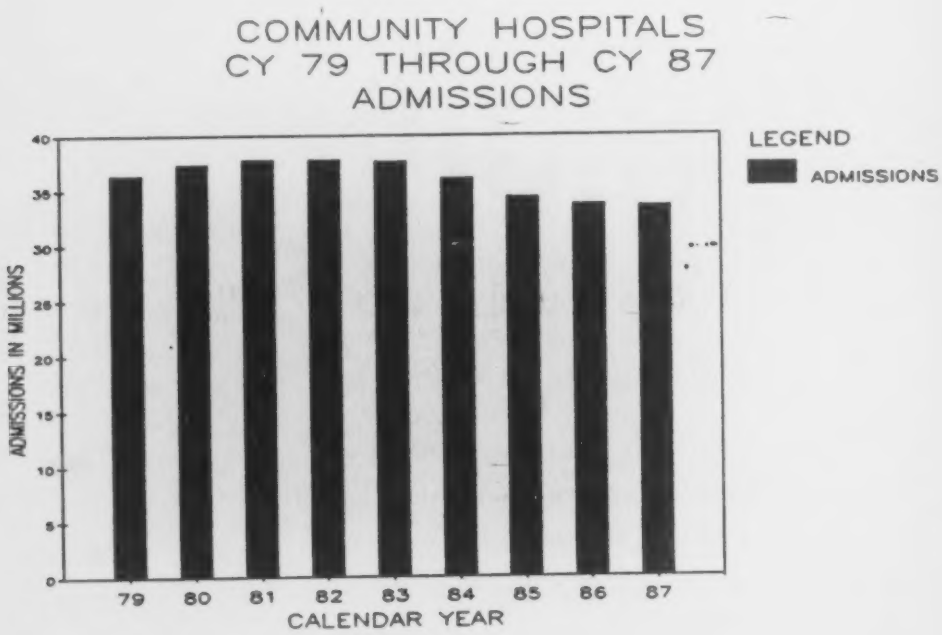


FIGURE 3

Outpatient visits provided by community hospitals have increased at a rate comparable to the VA experience. (Figure 4)

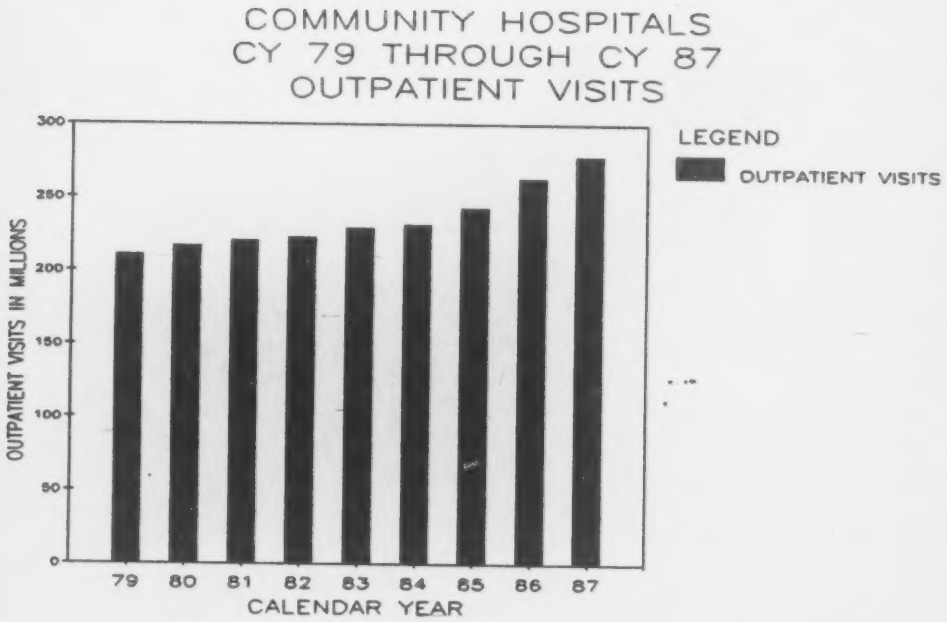


Figure 4

However, when the aggregate cost of operating community hospitals is reviewed, it is apparent that the community hospital sector has experienced an increased real cost of some 20 percent, adjusted for inflation. (Figure 5)

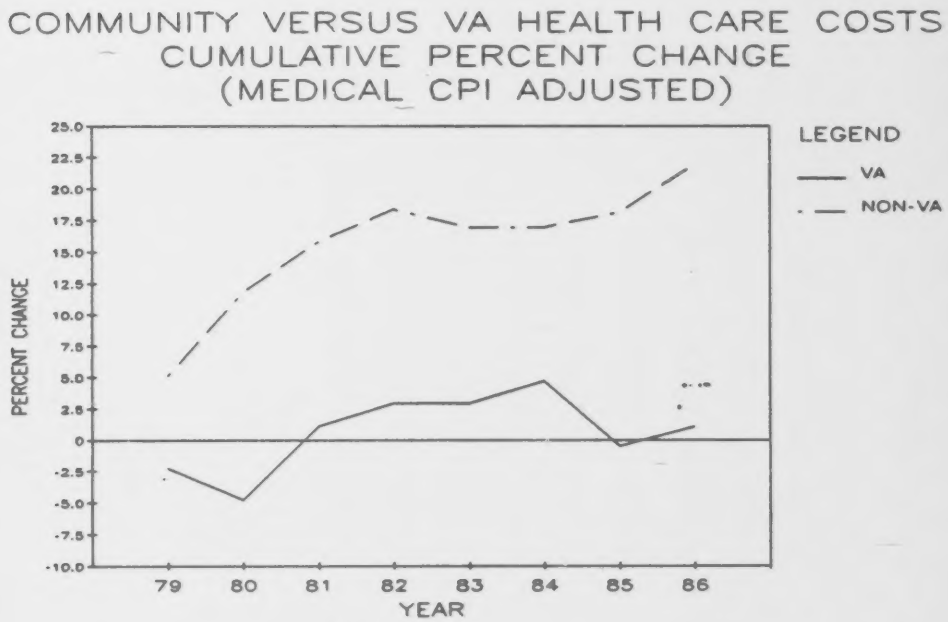


Figure 5

In summary then, during the past decade community hospitals have had a declining number of hospital admissions with increased outpatient care and a 20 percent real increase in cost. The VA, by contrast, has been able to accomplish an increase in both inpatient and outpatient care with no real increase in cost to the tax payers.

The Veterans Administration believes that this major emphasis by DM&S during the past decade on expanding productivity in order to extend the amount of care delivered to veterans has constituted sound public policy. This accomplishment has, in fact, this year been formally recognized by presentation to the Department of Medicine and Surgery of a special award from the President's Council on Management Improvement, one of a small number of such awards given after government-wide review of program productivity.

The Department of Medicine and Surgery has accomplished this enviable record by adopting a number of management approaches and budgetary incentives focused on productivity. It is the policy of the VA to operate and maintain a sufficient number of beds to meet the needs of veterans applying for admission and found to be in need of hospital care or medical services and to maintain additional beds as necessary for contingency purposes.

38 U.S.C. 5010 sets the minimum number at 90,000 combined hospital and nursing home beds. At the time legislation was passed setting this floor, it was appropriate for the VA to operate at that level. Since that time, patterns of patient care have changed and lengths of stay have decreased. We now can serve the same number of patients in fewer beds. The VA hospital bed occupancy rate in Fiscal Year 1987 was 71 percent, while the private sector operated at 63 percent for community beds. The current VA occupancy rate is 73 percent. The level used in planning for the future is a more efficient and cost effective level of 85 percent which can be achieved by reducing the level of operating beds while maintaining the age-adjusted level of patients treated. Ultimately the appropriate level of needed beds will be dictated by patient demand, acuity of patients treated, and availability of staff to provide high quality and cost effective care.

Our demonstrated ability to treat more veterans this year has been accomplished despite certain difficulties. At the close of Fiscal Year 1987, as a result of the nursing shortage, 1,890 hospital beds across the system were closed. As of June 30 this year, over 2,400 beds were closed for this reason. In spite of this, the most recent report of hospital patients treated showed that the department has actually treated 4.4 percent more patients than had been predicted in the Fiscal Year 1988 operating plan.

An additional contributor to both the quality of care and productivity has been the major emphasis on expanding care on an outpatient basis so that many procedures or conditions previously treated only in the hospital are now cared for on an ambulatory basis. The Department's Resource Allocation Model (RAM), now in its fourth year of implementation, has provided a powerful budgetary incentive for hospitals to control costs while expanding the amount of care given to veterans. During this period of increasing productivity, quality assurance reviews have been strengthened in order to avoid the possibility that individual patients would be short-changed in terms of quality as a way to achieve expanded productivity or quantity of care delivered.

It has been observed that "today's problems are often the result of the solutions designed to respond to yesterday's problems." In this regard, we believe that the Department of Medicine and Surgery is fully deserving of the public recognition which has been given to it for improved patient care productivity. As a result however, we at some point will be in a position of limited opportunity to make further internal expansions of productivity. Externally-mandated floors, ceilings, and other restrictions, however, have limited the Department's management flexibility.

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FISCAL YEAR 1988—A WATERSHED YEAR

Several unique and major factors make the current year, Fiscal Year 1988, a watershed year for the Department of Medicine and Surgery. The "bipartisan budget agreement", already referred to by the Administrator, established a clear mandate that the Department must operate within the resources provided in the initial appropriation, with a prohibition against seeking supplemental funding. The Department of Medicine and Surgery viewed this mandate with extraordinary seriousness, and planned its internal operation in such a way that we would do our share to contribute to the fiscal stability of the nation. Early in the second quarter of the year, a set of budget adjustments were made internal to the Department with this understanding in mind. VA medical center directors were given their "marching orders" with the allocation of funds for the remainder of the year. On this basis, I have continued to assure the Administrator, and I here today repeat that assurance to the Congress, that we have continued throughout this year to meet our responsibility to provide care to all veteran applicants who, by statute, "shall" be furnished VA care.

Several other unique phenomena have also impacted the Department's operations during this current year. The national shortage of nurses and other critical health professionals has required an array of responses to enable the Department to continue to ensure the availability of appropriate personnel for health care delivery. The nurse shortage is fundamentally a supply problem.

The available pool is shrinking and, faced with more lucrative options, nurses are leaving the profession. In some geographic areas, the VA finds it difficult to meet its need for nurses. However, while the nursing shortage in the private sector is 11 percent, VA's nursing shortage is approximately 4.6 percent.

To assist in encouraging talented men and women to remain in or to enter the nursing occupation, DM&S is addressing the disincentives common to the nursing occupation and those peculiar to the VA and/or Federal service. Specifically, the VA is seeking ways to improve the commonly accepted occupational deterrents, including undesirable working conditions, poor salary and benefits, and the lack of professional autonomy. To this end, the following initiatives are underway:

- establishment of a Program Office within DM&S to give national focus to recruitment and retention efforts/concerns and to serve as an information clearinghouse;

- provision of needed special salaries; and,

- enhancement of the VA's image as a health care employer, providing on-site child care facilities, and enhanced ADP capabilities.

These initiatives are designed to provide assistance to all of the occupations experiencing shortages. However, it must be noted that these initiatives as well as others already in place, such as special salary rates and Saturday premium pay, require significant funding. Special salary rates have now reached a level in excess of $100 million. Funds for these purposes have come from internal reallocations within the Department's operations and the need for additional funding has been recognized by the Congress with the $45 million for special pay in the Fiscal Year 1989 Appropriation. In addition, the expanding number of AIDS cases in the VA has created additional stress both in terms of resource needs and the additional demands on health care workers who must now take universal precautions to treat all blood and body fluids as though potentially infected.

The recently enacted Fiscal Year 1988 supplemental appropriation of $31.7 million allows relief for implementation of Public Law 100-322; which, with several mandatory provisions requiring implementation this fiscal year, had further stressed limited resources. Prior to receiving the supplemental appropriation, the Department had internally re-allocated resources from activation funds, nonrecurring maintenance funds and equipment accounts to provide for implementation of Saturday premium pay, expanded beneficiary travel, increased state home per diem rates, and expanded outpatient medical care eligibility. This fact was reported to the Congress by letter on July 6, 1988.

THE DECADE AHEAD-THE DECADE OF QUALITY

There is clear evidence that the country is now focusing increasing attention on the issue of quality of care and the resource implications of various quality measures. While cost considerations continue, this highly focused public concern about quality is joining the concern about costs as a major force behind health care system decisions. The first national steps have been taken to attempt a useful definition of "quality", and a quantitative approach to the identification of quality. This will allow more effective correction of deficiencies when inadequate quality is identified. The Veterans Administration has been and is committed to maintaining a leadership role in health care quality assurance activities. The review several years ago of each of the VA open heart surgery programs has been pointed to by health experts outside the VA as one of the most systematic reviews of quality followed by effective action in any health system. Specific legislation has been implemented (P.L. 99-166) mandating a review of VA surgical mortality, and more recently the VA has self-initiated a comprehensive review of mortality experience in all VAMCs in order to test the usefulness of mortality analysis as a measure of quality of care. This review is still in process, but a recent General Accounting Office report was complimentary of the review methodology being used by the VA.

While these first steps of the health care system toward a useful measurement of quality may be faltering ones, they are extraordinarily important in order to assure the public that our hospitals are concerned not only with quantity and cost of care, but with the quality of care available to every individual veteran patient. The Department has regularly stated its public commitment that quality of care will be protected. These steps to validate quality measures will allow the Department to deliver on that commitment.

The Department of Medicine and Surgery looks forward to the opportunity provided by this oversight hearing to clarify the current status of the Department's commitment to quality care for veterans, and to highlight the management options now being considered.

We will be pleased to respond to questions that the Committee may have.

MEMORANDUM OF AGREEMENT FOR THE NONRECURRING MAINTENANCE AND REPAIR (NRM) PROGRAM

PURPOSE:

This memorandum of agreement will establish policy, procedures, guidelines for planning, funding, and implementing the nonrecurring maintenance and repair (NRM) program with the Veterans Administration.

BACKGROUND:

The NRM program involves the replacement of major systems or major building segments (e.g., windows, ceilings), replacement of building service equipment, new building service equipment acquisitions, structural changes, space use changes, construction of additional or new space and installation of additional facilities and systems.

The NRM program can be defined by five basic components:

1. Maintenance and Repair (Capitalized): Maintenance and repair work that replaces major segments of: interior and exterior utility systems; individual building components (windows, flooring, roofing, etc.); and patient support and protection systems (medical air/oxygen/vacuum, sprinkler or fire alarm systems, etc.). This work adds value by extending the useful life of the structure and is capitalized.

2. Maintenance and Repair (Non-capitalized): Maintenance and repair work that prevents physical deterioration or offsets current deterioration of real property. This work maintains real property in good physical condition or restores it to such a condition that it may be utilized for its original or designed purpose. Since this type of work does not add to the value of real property, it is non-capitalized.

3. Building Service Equipment Replacement (BSER): Equipment that is procured and installed to replace items of like capacity and utility, including boilers for steam generation, electrical and air conditioning equipment, elevators, emergency (electrical) generators, pumps, water heaters, plumbing and electrical fixtures, etc.

4. Building Service Equipment Additional (BSEA): Equipment in this category is the same type as that described as BSER with the distinction being that it is installed where no like equipment items previously existed or where it is necessary to provide increased or expanded capacity of the existing system.

5. Minor Improvements (MI): Work which encompasses structural changes, additional space, new or expanded utilities, or alterations, modernizations and space utilization changes to buildings, structures or grounds. Projects classified as Minor Improvements are those where the majority of the work within the project is of a minor improvement nature, adds value to the structure, is capitalized and the minor improvement cost does not exceed $100,000.

Funds for the NRM program are included in the Medical Care Appropriation (0.23) and must be obligated in the year appropriated. There is no cost limitation on NRM work except that the total minor improvement portion of the project as defined above must not exceed $100,000. All funds from the NRM budget category must be utilized for specifically identified and approved nonrecurring maintenance and repair needs, except as provided for, to allow DM&S, with appropriate O/F coordination, to withhold the disbursement of any portion of these funds. NRM funds are not available to supplement other budget categories or other appropriations.

Prior to the realignment which established the Office of Facilities (O/F), Facilities Engineering, Planning and Construction Office (FEPAC), within the Department of Medicine and Surgery (DM&S), was responsible for the administration of the NRM program. This included reviewing proposed NRM projects, approving Central Office Approved projects (COAP), and coordinating with the DM&S Regional Directors the Regional Director Approved projects (RDAP). Funds were allotted to the facilities by DM&S's Resource Management Office upon request by FEPAC for COAP projects and via the Target Allowance for RDAP projects.

The Administrator's July 25, 1986, memorandum establishing O/F stated that the new O/F "will be responsible for all ... Nonrecurring Maintenance (NRM) project planning, design and construction ... In general, ... NRM projects will continue to be delegated by the Office of Facilities to the field for accomplishment in accordance with Office of Facilities management guidelines and oversight."

This Memorandum of Agreement establishes and clarifies the appropriate roles and responsibilities of O/F and DM&S in managing the NRM program. NRM program effectiveness requires the mutual support, communication and timely coordination of O/F and DM&S.

ROLES AND RESPONSIBILITIES

The roles and responsibilities in developing and administering the NRM program are established as follows:

NRM Budget Formulation:

1. DM&S will make final decisions regarding the level and distribution of funds within the NRM program. O/F will administer the NRM program and function as the program official, as DM&S FEPAC did prior to the realignment.

2. O/F will develop, with DM&S input, the initial budget proposal for the NRM program and submit it to DM&S Resource Management for inclusion and consideration in the DM&S budget development process. DM&S will have final approval.

3. O/F will propose for DM&S approval, the funding split between COAP and RDAP projects based on Departmental priorities, historical experience, project backlogs, five year plan, Facility Development Plans and capital facilities study information. A methodology to accomplish this funding split will be developed by O/F and DM&S.

4. O/F will propose for DM&S approval, the division of RDAP funds among the regions based on the factors described above.

NRM Project Selection:

1. O/F with DM&S (10B) concurrence, will prepare an annual call letter to VAMC's for submitting NRM projects.

2. VA Medical Centers will propose NRM projects. Projects will be submitted on VA Form 1193 to O/F's Office of Planning and Development (086A) by October 31 of the preceding fiscal year. For example, projects proposed for FY 1990 must be submitted by October 31, 1988.

3. O/F's Office of Planning and Development (086A) will coordinate the technical review of projects and place viable projects on a pending list. All projects which are not viable will be returned, with a detailed explanation, to the Medical Center after concurrence of the appropriate DM&S Regional Director. O/F will also review the pending list prior to project selection to ensure coordination with any minor or major project planned or currently ongoing at the facility.

4. O/F will make project specific recommendations regarding COAP project selections in accordance with DM&S priorities, e.g., life-safety related projects, and submit these selections to DM&S (10B) for final approval.

5. DM&S Regional Directors will select the RDAP projects from the pending list provided by O/F after COAP projects are selected.

6. DM&S Regional Directors will notify O/F of RDAP projects to be funded from monies targeted to each region and of changes in status of projects affected by the shifting of Regional Director priorities during the fiscal year.

During the fiscal year, requests for approved project funding adjustments will be submitted by the concerned DM&S facility to O/F (087) through the appropriate DM&S Regional Director. During the fiscal year, requests for additional new/emergency project approvals will be submitted by the concerned DM&S facility to O/F (086A) through the appropriate DM&S Regional Director. As appropriate, either 086A or 087 will coordinate the technical and/or funding review. Upon review completion, O/F will forward the request with their recommendation through the appropriate DM&S Regional Director to DM&S (10B) for approval. If approved, DM&S Resource Management will accomplish the appropriate funding adjustments with prompt notification to O/F in accordance with the funding processes outlined below.

NRM Project Funding:

Disbursement of NRM project funding will be accomplished by DM&S Regional Directors through their Target Allowance process or by the Transfer of Disbursing Authority (TDA) by DM&S Resource Management. All approved RDAP and COAP project funds will be released by DM&S as follows:

RDAP Projects: DM&S will allot funds upon availability to VAMCs after approval by the Regional Directors. Disbursement of funds by DM&S Regional Directors will be through the Target Allowance process.

COAP Projects: DM&S will initially allot all funds upon availability to VAMCs for those projects totaling less than $200,000 and design funds only for projects totaling $200,000 or more. Disbursement of these funds by DM&S Regional Directors will be through the Target Allowance process. Funds for construction contract awards on those projects totaling $200,000 or more will be allotted upon availability to the VAMC upon the VAMC's request and after design completion. Disbursement of these funds will be by the Transfer of Disbursing Authority (TDA) by DM&S Resource Management.

NRM Program Administration

All questions and/or comments regarding the status of NRM projects should be directed as follows:

1. DM&S's Regional Director field office (10BA) for any NRM project.

2. O/F's Office of Planning and Development (086A) for all non-approved NRM projects.

3. O/F's Office of Project Management (087) for all approved NRM projects.

All approved RDAP and COAP project funds will be released by DM&S within five working days of availability of funds.

On COAP projects totaling $200,000 or more, the VAMC's request for construction funding after design completion will be directed to O/F's (087). After O/F review, (087) will prepare and forward a funding request to DM&S Resource Management for appropriate disbursement. DM&S Resource Management will allot the required construction funds to the VAMC within five working days of receipt of this funding request.

To insure needed flexibility within the medical care appropriation and to provide adequate administration of the NRM program the following guidelines are also implemented:

1. DM&S will provide timely notification to O/F of their intention to withhold the disbursement of any portion or all RDAP funding.

2. DM&S will only withhold the disbursement of COAP funding upon written notification and concurrence of O/F.

O/F will maintain an NRM program status report for all NRM projects and provide a quarterly update to each DM&S Regional Director. During the last quarter of the fiscal year, NRM program status reports will be provided monthly.

Arthur J Lewis
Deputy Chief Medical Director (10A)

3/31/88
Date

E. R. Jensen
Director, Office of Facilities (08)

4/7/88
Date

DEVELOPMENT OF FY 90 NRM PROGRAM

O/F Develops Budget Proposal.....April 1988

VAMCs Submit Projects for NRM Program by.....October 31, 1988

O/F - DM&S Technical Review.....November 1988 thru January 1989

Medical District Directors
establish priorities and
submit lists through the
Regional Directors to VACO....January 21, 1989 thru February 15, 1989

O/F Recommends COAP Projects
from Pending List.....February 15, 1989 thru March 21, 1989

DM&S (10B) Approves COAP Projects.....March 31, 1989

O/F Provides Remaining Pending
List to Regional Directors.....April 3, 1989

Regional Directors Select RDAP Projects.....May 15, 1989

O/F Notifies DM&S Regional Directors,
DM&S (10B) and appropriate VAMCs of all
approved COAP and RDAP projects.....June 1, 1989

DM&S Distributes Funds to VAMCs for RDAP projects
and COAP projects under $200,000 and for
design of COAP projects $200,000 and over.....October 1989

DM&S Distributes Funds for construction of
COAP projects $200,000 and over.....October 1989 thru September 1990

STATEMENT FOR THE RECORD

BY

DONALD L. CUSTIS, M.D.

CONCERNING THE

CRITICAL SHORTFALLS IN THE QUANTITY AND QUALITY

OF CURRENT SERVICES THROUGHOUT THE VA HEALTH CARE DELIVERY SYSTEM

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SEPTEMBER 7, 1988

I appreciate this opportunity to add my voice to those expressing to this committee their concern regarding the critical shortfalls in the quantity and quality of current services throughout the VA health care delivery system.

As a staff editor of the Veterans Service Organizations' Annual Independent Budget, my information is derived from our retrieval and analysis of DM&S operations data and ongoing monitoring of medical services at the local facility level. Many indicators of declining health care services were cited in the FY'89 Independent Budget, together with anecdotal examples encountered through a telephone survey of twenty one VA hospitals conducted last November. It was reported that while out-patient workload had increased, underfunding and understaffing had led to unreasonable queuing in ambulatory clinics and denial of out-patient care to many category "A" non-service connected medically indigent patients whose timely care would obviate their future hospitalizations. Funds for prosthetic appliances were in critically short supply. Some hospitals reported an inability to provide expensive elective surgery. Reprogramming of equipment funds has caused a back-log of almost one billion dollars in acquisition requests for replacement of outdated equipment. Purchase of new expensive high technology is now prohibitive.

Subsequent surveys suggest that VA medical care delivery across the system continues to be caught in a rapidly descending spiral now reaching crisis proportion. For the past several years VA Central Office managers and

medical center directors have been able to adapt to the protracted dilemma of ever increasing demand for care in the face of ever decreasing resources by reprogramming funds from such other accounts as equipment, minor construction and plant maintenance to cover their payroll and bolster their medical care capability. Although the management options they resorted to were ultimately self defeating, they at least deserve recognition for their resourcefulness and courage under the stress of having to live within their inadequate budgets. Now, however, their administrative flexibility is largely gone and they face either deficit spending or still more drastic reductions in patient services.

Chairman Montgomery, I believe, has accurately diagnosed the situation. He has stated in the Congressional Record that "VA hospitals are suffering from serious professional staff shortages and insufficient funds to care for current work loads. The bottom line is insufficient funding. The annual productivity reductions mandated by OMB, inadequate funds for special pay and equipment and failure to request funds to implement new programs, have caught up with the agency." Other erosive factors have been the frequent requirement to absorb portions of employee pay raises, health benefits expense, and activation costs. There has also been a chronic budgetary failure to keep pace with the hospital market basket index.

Standard budget building procedure calls for upgrading the previous year's appropriation by the addition of uncontrollable new expenditures to arrive at current services level for the coming year. Because of circumstances referenced above, however, funding for the Department of Medicine and Surgery has been inadequate for several years. The current services dollar level will, therefore, be understandably understated when figured from an eroded resource base. Unfortunately, the FY'89 VSO independent budget identification of $10.8 billion for DM&S' current services was based on that same flawed premise. The administration's request, however, was even lower than that - by $400 million. Interestingly, DM&S' original budget, prior to its submission to OMB, identified a need for $11.4 billion. And if DM&S' FY'89 appropriation had been accorded the same proportion of the total budget for all federal health programs as it received in FY'85, the President would have requested $1.4 billion more than actually proposed.

Budgets, of course, cannot be built on such comparative proportions. It is difficult to know the true extent of the current DM&S budget shortfall. It would, perhaps, not be unreasonable to go back to the FY'85 DM&S appropriation and add not only the subsequent annual full increments for inflation, pay raises and activations, but also a cumulative figure to cover the intervening absorbed costs of new programs.

In any case, it is abundantly clear that a quick fix is needed. The situation is not unlike the acute need now manifested in the private medical sector where the American Hospital Association is urging Congress to provide relief next year for hospitals whose operating margins have been reduced to less than 1% stemming from a total budget cut of $21 billion in Medicare funding since the onset of the prospective payment system.

It has come to our attention that a CMD Task Force, including selected VA hospital managers, has submitted a report which predicts that the expected VA medical care appropriation for the coming fiscal year will represent a shortfall of well over $800 million. That, too, must surely be an under-estimate for the resources needed just to replace obsolete equipment exceeds that figure. The Task Force suggests a series of possible actions to live within the FY'89 budget. Each of their recommendations for cost savings are in themselves alarming. Taken together the options constitute a completely unacceptable recourse. A major recommendation is made in association with workload reductions. Many options carry with them FTEE reductions totaling 4,884. On the other hand, if none of the recommended program cancellations are enacted and personnel cuts are exclusively used to recoup $800 million, an 11,000 FTEE reduction would be required, this in a health care delivery system already understaffed.

The serious under staffing of nurses and certain other allied professionals is a problem common to the private medical sector. So critical is the nurse shortage in the VA that it alone accounts for thousands of closed beds, cut backs in operating room time and limitations in special therapeutic services. It is gratifying that Congress is already giving further attention to that problem.

Unfortunately, this staff shortage may soon be compounded by a shortage also of physicians. In 1990 when retirement income calculation will also incorporate full coverage of special incentive pay, a large exodus of doctors is anticipated. There are approximately 7,000 full-time and 5,500 part-time physicians currently employed by the VA. Taking a measure of just the full-time cadre alone, 1999 or 28% will become eligible for retirement by July of that year. Assuming a normal retirement rate of something less than 15%, approximately 300 of these physicians would retire in late 1990 or early 1991. This is the "best case" outcome. Given the added incentive of an individual's average additional $6,000 retirement income the system may realistically lose as many as 1000 full-time physicians within a relatively short period. Among those numbers are 77 retirement eligible Chiefs of Staff. If the majority of those do retire in that same time period, DM&S would experience a critical shortage of clinical mangers at their facilities.

The solution to that problem should not be deferred another year. There has been no inflation adjustment for physician incentive pay since 1979. Consideration might also be given to such options as a requirement for pay-back time for fellowship training and a medical school scholarship similar to the very successful health professional scholarship program of the Department of Defense.

Current under staffing accounts for only a portion of the closed beds across the VA hospital and nursing home system. The "phantom bed" phenomenon is also involved - beds which no longer exist although still included in the total bed count out of dishonest deference to the 90,000 statutory bed level. Under such circumstances the figures for percentages of bed occupancy must be grossly invalid. So fluid is the situation that it is doubtful Central Office ever has an accurate count of how many beds are truly operational, or to what extent work load potential is compromised. Solution to this problem should not include removal of the mandated bed level. Both it and the floor under the FTEE ceiling were put there by Congress for exceedingly good reasons, to which OMB can attest.

VA managers' concern regarding the acute problems besetting the veterans health care system is much in order. Their task force report also properly addresses strategies should fiscal shortfalls continue in future years. Although there is now an immediate and critical need for additional resources, preoccupation with the current crisis must not distract DM&S officials from the continued pursuit of long term strategies, the nature and need of which have long since been recognized:

A more equitable distribution of resources is required and better prevention of "gaming" the DRG/RAM effort.

A more valid needs assessment methodology should be developed and the process improved by which the department justifies its needs to OMB and to Congress. The current system of VA budget formulation does not permit Congress to be fully informed of resource requirements. Frustration with current OMB budget obfuscation is what motivated the Veterans Service Organizations to offer Congress their own version of an independent VA budget.

Ten years ago, by congressional direction, the VA first published the results of its study of projected health care requirements with reference to the increasing average age of the eligible veteran population. Five years ago, following more extensive demographic analyses, a sequel publication "Caring for the Older Veteran" further quantified the implications of the veteran aging impact. The statistical content of that 1984 report was corroborated in surveys by the Louis Harris Associates and the Congressional Budget Office. Accompanying goals and objectives featured a reorientation of the VA health care system to emphasize long term care services and expand such non-institutional modalities of care as ambulatory clinics, adult day care centers, hospital based home care services, hospices and outreach programs. Targets for additional GRECCS, geriatric evaluation units and nursing home beds were established, the latter to include conversion of sizeable numbers of excess hospital beds. Progress toward meeting these

targets has been exceedingly slow. Virtually no progress at all has thus far been accomplished in converting excess acute hospital beds to nursing home units.

Whereas, the 1988 average daily census of veterans in nursing homes (VA owned, community and state) was 34,000, that number is expected to reach 47,000 by 1995. The VA and the nation will be ill prepared to meet this aging impact. There are secondary care VA hospitals in geographic proximity to tertiary VA facilities which should be totally converted to nursing homes.

If federal budget austerity continues and resource requirements for VA health care needs cannot be met, any further horizontal cuts should be avoided in favor of vertical closures of less efficient and least needed facilities. Considering the impediments to mission change of VA hospitals, or closure of facilities and realignment of the system, perhaps such initiatives should be assumed by the Congress. There is the example of the DOD model which was recently enacted by the House to facilitate the selected closures of excess military installations.

Sharing of programs and facilities between VA and DOD have thus far been very successful, particularly the VA/Air Force occupancy of VAMC Albuquerque. Further pursuit of that potential could be mutually advantageous and cost effective.

Finally, long term strategy must also take into account changes in the private health care sector which exert demonstrable influence on the VA system. Resource cuts in Medicare and Medicaid have generated increased demand for access to the VA health care system, a currently incapable safety net.

Veterans are grateful for this committee's steadfast support of their health care system. They are mindful also that it is a national asset in the nation's health manpower production effort and medical research capability. There is another important factor to consider: The VA's major role in the National Disaster Medical System (NDMS). This system is designed to provide

emergency preparedness on a national scale. It is to handle casualties numbering tens of thousands when cataclysmic domestic disaster (e.g. an earthquake) has saturated local and state resources. In the event of a conventional military conflict, with large numbers of casualties arriving back in the United States, the NDMS would be an essential on-line contingency backup resource for the Department of Defense.

Right now the VA health care delivery system particularly needs and deserves your help.

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TESTIMONY OF

PAUL W. SCHAFER, M.D.

EXECUTIVE DIRECTOR

NATIONAL ASSOCIATION OF VA PHYSICIANS (NAVAP)

AT THE HEARING

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS' AFFAIRS

SEPTEMBER 7, 1988

My name is Paul W. Schafer. Though I am employed full-time by the VA as Chief of Thoracic Surgery at the Washington, DC VA Medical Center, I speak here today in a strictly unofficial capacity as Executive Director of the National Association of VA Physicians (NAVAP). I was formerly Chief of Thoracic and Cardiovascular Surgery at the Walter Reed Army Medical Center where I trained a whole generation of the Army's surgeons who served with distinction in those specialities in Korea and Viet Nam. Prior to that I was Professor and Chairman of the Department of Surgery at the University of Kansas School of Medicine. My present academic appointment is Professor of Surgery (VA) Georgetown University. My government service, both military and civilian, and my private sector experience, academic and otherwise, have spanned the past half century. The last nearly 25 years have been spent in service to the Veterans Medical Program. I present my credentials as a reference for a professional institutional memory not all that easy to come by in recent years as Administrators, their Deputies, and Chief Medical Directors have moved rapidly into and out of the System.

We are appreciative of this opportunity to present our perceptions concerning the budget crisis and the effect it is having on the care of veterans and on the health care providers who serve them. I would also like to express my gratitude for the opportunity to serve deserving veterans very much in need of first class medical care, to carry out fundamental biological research, to teach medical students, to train post-graduate house officers, and to be part of a health care team with an esprit de corps derived from values based on merit and health care decisions of the highest quality uncompromised by monetary distractions. Coming from a background in the competitive, mercenary, entrepreneurial world of academic and private practice; first at Walter Reed and then in the VA, "Oh, what a joy it was to do for patients the very best that could be done without having to make decisions based on what it was going to cost." And to be able to do research and to teach based only on merit and competence. Not surprising, the esprit de corps. I submit to you that my patients have received care that will match that the most affluent could buy in the best of the private sector and care better than most receive elsewhere. And my service in the Veterans Medical Program is not a singularity.

Unfortunately such a bright picture will not much longer exist unless present day realities are addressed and long overdue changes are brought about. Time available in this forum will not permit more than a thumbnail sketch of these perceptions but perhaps by looking at the history of the Program we may avoid having to relive some of its past horrors. The Veterans Administration came into being July 3, 1930 during the Hoover Administration when several national functions pertaining to veterans were consolidated together with the Veterans Bureau as a new Agency. Having been Head of the Veterans Bureau for the prior seven years Brigadier General Frank T. Hines became Administrator of the New Agency. Dr. Charles M. Griffith became its Medical Director in 1931 and served in that post until 1945, longer than any other person. It is a charitable characterization to say that veterans' medicine up to World War II was practiced under conditions which would not assure a continuing diffusion of the highest standards of medical care throughout the system. Veterans' Medicine as viewed from the outside appeared to be a tight little world of veterans' benefits, veterans' forms, and military-like transfers of physicians between stations -- a world isolated from the rest of American medical practice, research, and education -- a self-imposed parochialism. VA physicians were not even accepted into the brotherhood of organized medicine. The American Medical Association (AMA) not only denied them membership, it opposed federal medical care for veterans except for strictly defined service connections.

World War II became a test which the Hines-Griffith VA leadership failed. During the War, American citizens on the home and battle fronts read about, saw, or experienced a variety of dramatic advances. Among these were: the effective use of penicillin and blood plasma and other blood derivatives; new techniques in neurosurgery, chest surgery, and plastic surgery; new treatments for neuropsychiatric ailments; speedier convalescence of the wounded; improved prosthetic devices for amputees; new drugs for tropical diseases; and the saving of the lives and even restoration to social and economic usefulness of paraplegics and quadriplegics. The American people, many in Service and many with family members in Service, were becoming increasingly knowledgeable about medical progress -- medicine's mystery was gone. Americans were directly concerned about veterans' care, their motivation to evaluate and criticize was high. It was not surprising that the quality of VA medicine came under fire by the print media, further arousing public reaction. It was later said, "Medical treatment was so far below standard that the newspapers were beginning to note the smell." Before the War was over this thing was going to blow up into a first-class nationwide scandal of bad treatment, costly blunders, and administrative incompetence. The situation was a perfect example of bureaucracy at its worst.

In 1945, with the War ended, VA hospitals were filled to overflowing with sick and disabled men and were critically short of doctors because of Civil Service red tape and the bad repute of VA medicine. The predicted scandal was at hand. President Truman tasked General Omar Bradley to straighten out the mess. To head up VA medicine Bradley brought with him Major General Paul Hawley who had been European Theatre Surgeon General. Convinced that the new VA leadership was serious about taking VA medicine out from under the Civil Service, a firebrand Chicago orthopedic surgeon, Northwestern University Professor Paul Magnuson became part of the team. The legislative instrument designed to free VA medicine, Public Law 293, was passed almost unanimously by the 79th Congress just before it adjourned for the 1945 Christmas and New Year Holidays. All that remained was the President's signature before January 3, 1946 to prevent its nullification by pocket veto. The serried ranks of the Civil Service Commission were not about to go down without a fight. The 72 hours spanning the New Year 1946 saw a high stakes battle between Mr. ~~Arthur S.~~ Fleming of the Civil Service Commission and President Truman's Assistant Zimmerman on the one side opposing Bradley, Hawley, and Magnuson. The last arguments in the struggle took place in the President's Office the afternoon of January 2. Later that afternoon the President signed PL 293 into law. This action, though it brought countless benefits to VA medicine and to America's veterans led ironically to the many problems being in part addressed today. To understand this circumstance one must look to the early implementations of the new law. Central to the new effort was what was to become known as the Hawley/Magnuson Plan. It can be traced to a five-page double-spaced memorandum on Dr. Magnuson's personal letter stationery which is now in the Archives of Northwestern University. It's author described the Plan as follows, "This is what I believe General Hawley has in mind for the immediate future for staffing of Veterans Hospitals and for cooperation with teaching institutions. I took Hawley to lunch and after the waiter had cleared the table, Hawley went over the plan with a pencil underlining sentences for emphasis, adding a word or a clause here or there to strengthen the statement. He put his big "PRH" on every key paragraph. This was it, the *modus operandi* of what was to be known as the Dean's Committee Plan." Its official counterpart is General Bradley's famous January 30, 1946 Policy Memorandum #2 which these 42 years later remains unrevised. Such informal, often personal, maverick initiatives, allowed the job of caring for America's veterans to get done, little worry being expressed about the way government usually did its business. Blind faith of the parties concerned is evidenced by the fact that not a single document was struck which identified and bore the signatures of the officials having legal competence to commit the government and the medical schools. Much of the totally new

look of VA medicine in the coming years was due to "gentlemens' agreements". Though many Agency-wide instructions such as manuals, circulars, technical bulletins, directives, memoranda, interim issues, etc. have been promulgated over the years, there has been little modification of the basic principles and procedures first cited. We thus today have an Agency with a vital mission of caring for the Nation's veterans, second only to the Department of Defense in the number of its employees, including those who are in Title 38, who work under a set of never published nor adequately promulgated conditions of their employment. But from these auspicious developments, great and good things did flow. Most importantly returning World War II veterans did receive the best of care. One must read the documents of this era for a sense of the energy, excitement, and pride which went hand in hand with these good works. Particularly recommended are:

1. Ring the Night Bell, The Autobiography of a Surgeon, by Paul B. Magnuson, Little, Brown and Company, Boston and Toronto, Copyright 1960, Library of Congress Catalog Card No. 60-6031 - First edition. This is now available in paperback from the University of Alabama School of Medicine Press, 1986.

2. Medical Care of Veterans, ...to care for him who shall have borne the battle..... Published by The Veterans Administration 1967, U.S. Government Printing Office, Washington: 1967. This is essentially the work of Mr. Robinson E. Atkins who was associated with the Department of Medicine and Surgery from its inception. To a great extent he was one of the guiding forces in the growth and development of DM&S as it is now recognized. His official title from May 1946 on was Executive Officer in the Department of Medicine and Surgery. In that position he acted as principal administrative advisor and top assistant to VA Chief Medical Directors Hawley, Magnuson, Boone and Middleton.

3. VA Medical Program in Relation to Medical Schools, U.S. Cong. 91st 2nd Session House Committee Print No. 170, by Benjamin J. Lewis. Prepared for the Committee on Veterans' Affairs, U.S. Government Printing Office, Washington: 1970. This volume is essentially Dr. Lewis' Ph.D. thesis for the School of Government and Public Administration of the American University, Washington, DC. Dr. Lewis was an employee of the Veterans Administration for more than two decades and the work reported in his doctoral thesis represents five years of research, documentation, and analysis of the affiliation relationship between hospitals of the Veterans Administration and the medical schools of America. Though he was an employee of the Veterans Administration, Dr. Lewis' approach is a completely independent one, with no restraints on expression or on findings.

My reason for review of those times is that one will surely come to see the present time with a frightening sense of Deja vu. Though today's Veterans Medical Program is a far cry away from its sad World War II state, it has lost much of its bright promise of the 50s and the 60s. And the reasons for this are not all that dissimilar from those which caused its earlier affliction.

The first of these is money -- far too little of it. For years now the Agency's leadership has been unreasonably low in making its estimate of the amount of funding needed properly to carry out its mission, this underestimation often being on orders from the Administration itself. Regularly the Administration's Office of Management and Budget aggressively slashes whatever requests have been made and with about the same regularity VA Administrators have been less than vigorous in their protests of OMB Passbacks. For at least the past 12 years successive Presidents have sent a budget message to the Congress which has just not adequately reflected the needs of the Veterans Medical Program. For eight years the present Administration has poured unimaginable treasure into the Budget for our Department of Defense, never once seeming to recognize its obligation to care for its veterans as being an integral part of the

cost of war; indeed, it has been said that in reality veterans are the DoD's only product. Honoring War's dead in photo-opportunities is no substitute for honoring the Nation's contract to care for those who survive. The fate of civilizations like that of the Romans, which in the end failed to honor its triumphant legions, awaits those who repeat the same mistake. Let ours not be one of them.

Cognizant of such inadequacies in the President's Budget, the past two years several of the Veterans Service Organizations have presented to the Congress an "Independent Budget" which has more realistically addressed current services needs with here and there modest funding enhancements. NAVAP has on each of these occasions joined in support of these budgets. Regularly the Congress has ended up appropriating more funds for Department of Medicine and Surgery Medical Care than the amounts requested by the President. But the fact remains that for the past 12 years as more and more new demands have been placed on the Program, funding in deflated dollars has been straight-lined; indeed, the Budget for Fiscal Year 1989 provides for only about 1/2 of the predicted inflator which is already recognized as an underestimate. As if this were not enough we now learn that with the VA Appropriation being grouped together with other Agencies in the HUD and Independent Agencies Appropriation that another government agency in this group, the National Aeronautics and Space Administration, has been given $25,000,000 of the VA's Medical Care funds to support its space shuttle program. At least this funding hazard should be minimized with elevation of the Veterans Administration to Departmental status. But all this having been said the fact remains that more money is needed if veterans are to receive the first class health care they need and deserve. There must be a more adequate Emergency Supplemental Appropriation for the remainder of FY88 and a much more realistic treatment of FY89 needs; without which the present conditions which will later be identified may be allowed to progress to a point beyond retrieval. There is still time to salvage the situation but it does require action now.

But now as then, more money alone will not suffice for solution of the Veterans Medical Program's problems. **The Program's management must be subjected to critical scrutiny. Succinctly there is too much of it, and much of it is bad.** The sheer disproportionate numbers of persons employed in administrative roles and the inflated importance assigned to their roles in relation to the numbers and importance of direct health care providers is nearly at an obscene level. If this is allowed to continue, medical care of veterans will be hard to find in a Program that does virtually nothing but administer itself. Tables of organization have been created which imply equality as between the Chief of a Major Bed Service such as Medicine with the Chief of an Administrative Service such as Medical Media Production. With rare exception Facility Directors and their second in command, called an Associate Facility Director, ascend the ladder of advancement from the ranks of administrative services with the most senior direct health care provider, the Chief of Staff, being third in command. Leadership roles have for all practical purposes been careers closed to bright young men and women physicians who might otherwise prepare for them. The Agency is so fearful of identifying the background and origin of its Facility Directors and Associate Facility Directors that for 8 years it has failed to respond to NAVAP's request for such information made under the Freedom of Information Act. The last response we have obtained is dated January 25, 1980 and revealed that of 151 Facility Directors, 27 were without any academic credentials much beyond their high school certificates. It is assumed that this situation has improved but we have been denied any proof to support this assumption. But in addition to exclusion from management of the largest talent pool of persons most knowledgeable as to what health care is all about, we have had foisted onto us one unrealistic management scheme after another. Recently one was called Medical District Initiated Program Planning (MEDIPP). This scheme was thought to insure that direct health care providers at the

grass roots level, given such a glorious input into definition of program needs and into the creations of policies, would supply top management in VA Central Office with a plethora of material which could then be used to persuade a doubting Congress. The Chief Medical Director who is most prideful of this program had forgotten that a year before MEDIPP was announced the only physicians serving as members of the 27 Medical District Executive Committees; namely, Chiefs of Staff, had been removed from the District Executive Committees' membership. The energies and resources directed into this ill-conceived MEDIPP program represent fruitless waste in what has now become a laughing stock.

But they never learn. Now we have Diagnosis Related Groups as a basis for Resource Allocation Methodology (DRG/RAM for short), a completely predictable failure; what would seem to be an unfulfilled Agency death wish which now appears to be in its last agonal convulsions. It is to hoped that new faces can be directed toward the application of meaningful management arts and skills. The private health care sector's fall-out from the decision to reference Medicare payments on diagnosis related groups and their singular length-of-stay indicator (LOS) is as nothing compared to what has happened in the Veterans Medical Program. The Agency's Me-Too, Knee-Jerk adoption of DRG's as its sole reference for managing the allocation of resources (RAM) failed totally to recognize fundamental differences in the public and private health care sectors. Even a new currency had to be created; work units rather than dollars, and these then had to be weighted (WWU). Thus was the stage set for the new game upon which everybody in the Agency was to focus their attention - not on a proper, full-time attention to providing the best possible health care for our veteran beneficiary patients. Oh, Yes, the game had to be laid out with rules which would allow curves to be drawn for each one of the 469 DRGs through high and low "trim points" so that individual patient's LOS could be said or could be made to seem to have earned the maximal WWUs, which could be aggregated into totals, which could be compared with the paper "earnings" of all 172 medical centers, which could then be assigned to groups based on their performance in generating WWUs in respect to the number of dollars ($) they had been allocated to spend. The annual grand finale of this new game, its Super Bowl or World Series, was said to occur when all of the individual group facility net gains and losses (WWUs/$) were tabulated and published with prizes and penalties taking the form of dollars ($s) to be made available to each facility to play the game (DRG/RAM) during the next fiscal year. And the driving emotional force in all of this charade was the sense of guilt created in the players, those who bore the stigmata of not having done their best and particularly in those who were actual WWU/$ losers.

This DRG/RAM management disaster has now been in place just long enough finally to be recognized for the damage it has caused, not the least reason being the precious scarce funds for patient care which Facility Directors, Regions and Central Office have diverted to DRG/RAM administration and to the hiring of an army of personnel considered to have expertise in playing the new game. Millions of dollars in medical care funds have been diverted to this purpose. Time, energy, and the focus of health care providers have been diverted to the game at the expense of patient care. Quality Assurance has been increasingly blurred by Utilization Review. Funds for DRG/RAM gamesmanship mean fewer health care FTEE, less support of clinical investigators and scientistis and research in general, less money for supplies and equipment, fewer hospital beds and less ambulatory, intermediate and nursing home care, delays, etc. for veteran patients, "Sicker and Quicker" discharge of veterans who have been unable to get into our hospitals; and perhaps, most of all, the creation of a reference for admitting, treating, and discharging patients that replaces the only valid reference; namely, what is best for the patient. In addition DRG/RAM has the real potential of making the patient's record a

fiction rather than an accurate documentation of the patient's experience. NAVAP has repeatedly called for the termination of this travesty. We now represent that the time has come for all to recognize that DRG/RAM is a failure and should be eliminated. From the many telephone calls and letters which come into National NAVAP Headquarters with increasing frequency in each passing week, it is apparent that local facility managers play the DRG/RAM game by contradictory interpretations of its rules. The plight of individual VA physicians caught up in this pressure cooker experience illustrate a whole spectrum of Catch-22 possibilities. The following example is submitted for your reflection:

> *From the Memphis, TN VAMC: John J. McCaughan, M.D. is a prominent member of the social, academic, and professional Memphis community. He is a well-established and highly regarded vascular surgeon who trained under and succeeded Ralph Bowers, M.D. who was the first Chief of Surgery of the largest World War II Army Hospital as it became the Memphis VA Hospital after the War. Dr. McCaughan has developed and run one of the finest surgical services in the VA System. Imagine his shock upon being summarily removed from his position as Chief of Surgery by Memphis Facility Director, Mr. Kenneth L. Mulholland, Jr., a former male orderly, who charged that Dr. McCaughan had been insufficiently attentive and involved in the paper work production needed by their Utilization Review, Quality Assurance, nee DRG/RAM activities. Dr. McCaughan readily admits that he spent his time on running the Memphis VAMC Surgery Service to the best of his ability, rather than participating in what seemed to him to be senseless and wasteful gamesmanship with people who most times were so ill-equipped for the tasks they undertook that he wondered if they could distinguish between a coronary artery bypass and a vegetable patch. And irony of ironies, after last years' publication of National DRG/RAM Performance Statistics, Dr. McCaughan began to receive telephone calls from fellow surgery chiefs asking how his surgery service had achieved the highest net WWU/$ gain in the entire nation. As yet he has received nothing but dreck from his Facility Director, Kenneth L. Mulholland or his Chief of Staff, David M. Mirvis, M.D.*

In our last issue of NAVAP NEWS we warned our members as follows: *With this issue all NAVAP members should go on alert that this game can best be regarded as a mine field to be treated with great care. Know that facility managers are under tremendous pressure from VACO and Region not to reveal the terrible economic mess the VA is in. The new absurdity being promoted is that dollars are not required to improve the quality of care, only quantity requires dollars. As one NAVAP District Director puts it, 'This austerity program is ripping the guts out of the VA Medical Care System.'*

Though it is finally becoming obvious that DRG/RAM/WWU is a disreputable system that breeds manipulation and fraud, managers will continue to press it on you until this obscenity can be added to the long list of other misguided ill-conceptions. Do not be surprised if managers close their eyes and ears to all sorts of DRG manipulations that will make WWUs, and even unofficially condone or order (verbal) them until someone blows the whistle. When the powers that be call for blood, watch them scramble to find a fall-guy or gal. Don't be one!!!

Most importantly don't let this highly touted gamesmanship that is being played distract you from the reality that the Veterans Medical Program and our reason for serving in it has one overriding reality and that is to provide for our veteran patients the highest quality of care that can be achieved. Anything that

compromises this fundamental purpose should be regarded as dreck. The patient's medical record is a most valuable document which must accurately and completely define the patient's experience while under our care. Lay managers have many proper administrative functions which do not include patient care. Perhaps the time has finally come for entrance onto administrative career tracts to be reopened to bright young men and women physicians who do know the difference.

And finally we come to the last item in our 3M kit of particulars. **We now add mean-spiritedness to money and management** as not the least debilitating influence being felt in the Veterans Medical Program. Top VA Administrators threaten Facility Managers with dire consequences if they open their mouths about the current fiscal crisis they face. VA General Counsel exudes an antediluvian lack of sensitivity and its opinions reflect an arbitrary perspective that the Agency is always right and any one at odds with it, regardless of merit, is to be found in error. The Administrator's Office of Employee and Labor Relations views all Agency employees with a single hostile defensive attitude that brooks no distinction between a physician and a housekeeping clerk in the roles they play in a complex health care delivery organization. The Inspector General runs rough-shod through the Organization accusing physicians of malpractice, licensure defects, moral turpitude, drug abuse, and payola; and leaks these unsupported data to favored media sources which loudly trumpet these flawed charges which go unremarked as they later are proved on careful review to be essentially without merit. The Agency considers section 4108 of Title 38 U.S.C. to give the VA Administrator the absolute unfettered right to promulgate rules concerning the working conditions of all Title 38 personnel. These rules, such as are to be found in facility personnel offices, have never been formally published in the Code of Federal Regulations. They are a disorganized collection of all sort of documents with hand-written additions, hand-written cross-outs, revisions and portions that are cut and pasted, in short, such a confused reference, a hodgepodge, that it is a common occurrence for personnel officers to admit their inability to answer simple questions. Referrals of question to higher authority in Central Office is equally unrewarding with ambiguous responses being made after months of delay, if they are made at all. The Agency has stonewalled all efforts to have a meaningful set of rules published. In general, as they now exist, they would evoke outrage if they were to see the light of day. In most matters the VA acts as prosecutor, judge, and jury with the Title 38 professional having almost no due process or other rights. Almost half of the 13,000 physicians who are employed part-time by the VA have essentially no rights. They can be and are fired without notice, without cause; indeed, for no cause at all. Even physicians employed full-time and who have achieved "tenure" have essentially only the right to be employed, at least so long as other available pressures have not been brought to bear. It would certainly seem that the time has come for substantial constructive treatment of Section 4108 of Title 38 U.S.C.

These and many other considerations were discussed at NAVAP's Fourteenth Annual Meeting this past June 4. On being present and hearing such allegations, the managing editor of U.S. Medicine was moved to send a ten point questionnaire to all VA facility Chiefs of Staff. Their responses will be featured in the August and September issues of that publication. The texts of these articles have been given to me with permission to include them in my submitted testimony. This I have done. I am sure you will find them to be as revealing as I have.

We are also reliving events nearly identical to those which existed back in 1974 which were in large part responsible for the founding of the National Association of VA Physicians. Then, as now, the Uniformed Services were facing a crisis in the recruitment and retention of a sufficient number of high quality physicians to meet the needs of the several services. It was recognized that their salaries had become non-

competitive in the common marketplace from whence all physicians come. Legislative initiatives were undertaken to obtain salary augmentation in the form of Special Pay for physicians. The VA on being offered the opportunity to join in this action responded that no such recruitment and retention problems existed in respect to VA physicians and thus opted out. The fact was that the VA did have serious physician recruitment and retention problems and these were addressed by the newly formed NAVAP which with major helpful assistance from the Veterans Service Organizations and the dedicated Committees of the Congress obtained passage of P.L. 94-123, which provided modest Special Pay for VA physicians and insured continuing first-class health care for veterans. A comparable result was obtained in 1980 by passage of P.L. 96-330.

We are now aware that the Uniformed Services are again facing physician recruitment problems of crisis proportions and that efforts are again underway to obtain legislative solutions. We do not know whether the Veterans Administration is either knowledgeable or interested in these developments. We do know that VA physicians have had a 25% loss of deflated dollar income since 1980 and that there has occurred an almost revolutionary change in VA physician staffs during this period, a change more than a whole order greater than that which has occurred in the Uniformed Services. It is illustrated in the histogram which you have seen as the last page of my submitted testimony and which I will only summarize here. By way of comparison the Navy's total physician loss for the years 1985, 1986, 1987 and 1988 (proj.) was 57, 56, 84 and 94 respectively. In starting contrast the average VA physician loss for the last 7 years has been 1,568 per year with peaks occurring in 1981 and 1982 as a result of P.L. 97-72 which, without a grandfather clause, changed the method of computing annuity benefits for part-time service, a most egregiously unfair and damaging piece of legislation that continues to have major negative effects. A second peak has just been experienced in 1986 and 1987 which years represent losses of 1,924 and 1,852 respectively. These result from the provision in P.L. 96-330 which caused 50% of physician Special Pay to be included in calculation of annuity benefits for those who retire subsequent to October 1, 1985. The next disastrous loss will occur after October 1, 1990 when 100% of Special Pay will be included in annuity benefit calculations.

As the graphic clearly shows these losses over the last several years have included a very substantial number of highly qualified, experienced, senior physicians, a total of 5,477 to be precise. Though younger, less experienced physicians have been hired to keep rosters filled, during the last six years almost 4,000 of them have served for less than 2 years, many for less than one year. Many have served for only a short time beyond 2 years, waiting only until the right contacts had been made for them to enter private practice.

These changes have been analyzed in some detail for the last year for which we have complete computerized records. During calendar 1987, 1,832 physicians left the System and 1,888 were hired. But this numerical replacement was far from a quality replacement. Among the 1,832 who left, our records show that 575 were senior, experienced physicians, 440 of whom were certified by their professional boards, a distinction only a handful of their 1,888 replacements brought to their service in the Veterans Medical Program. Diminished quality in psychiatric staffing is so severe that this field will require designation as a scarce specialty if improved recruitment is to occur. Though money does not alone reflect quality, it is still axiomatic that you get what you pay for. It should be noted that approximately a third of the replacements were hired at significantly low salary levels and the track record for their predecessors would clearly suggest that many will stay only until they have passed their board examinations and have been certified in their specialties. And this is in no way meant to be critical of them, it is merely to underline the fact that only a few can be counted on to elect a career of service with the Veterans Medical Program. These are bright young men and women

physicians who above all should be in all possible ways encouraged to serve veterans' needs. What we are now exposing them to hardly serves that purpose:

* In this last quarter of the fiscal year 1988 they work in VA medical centers that have very nearly run out of money.
* They see such a severe shortage of nurses that wards have been closed; though this is not admitted; and they see medical, surgical, and other intensive care facilities with patient stations that cannot be used.
* They can no longer be sure that ordered medications are actually being administered to their patients in need.
* They see staff and resident physicians and they themselves under pressure to make critical diagnostic and therapeutic decisions about their patients more relevant to the WWU/$ net result than what is really in their patient's best interest. "Sicker and Quicker" discharges are now a reality.
* They are involved in failed urgent and emergency communications that are placing patients in jeopardy. Without an adequate support staff, not even anyone to answer the telephone, reliance on answering machines and pagers has been the order of the day. No funds are available to repair or replace these devices as they fail with increasing frequency.
* At one tertiary care VAMC they would see the following deficiences:
  *20 of the 25 kidney dialysis machines are obsolete and inadequate.
  *G-I endoscopy equipment is outdated and constantly breaking down.
  *Respiratory therapy ventilators are largely obsolete. They are unsafe for patient use and when used make it almost impossible to wean patients off.
  *Cardiologists feel they had an avoidable death, a veteran who could have been saved if their two aortic balloon pumps had not been broken down.
* Laboratory Services can no longer perform many of the tests needed by their patients. There is no money to buy the needed supplies. Their patients wait days for those that are still permitted, only to find that some of these cannot be done because the equipment is broken and can't be repaired or replaced -- no funds. The other day a pathologist told me that his service could not even buy a grindstone to sharpen their knives and the one they have has been worn so smooth that it no longer is useable. That's akin to arming a combat infantryman with a toy gun.
* Pharmacy Services can dispense only a much curtailed list of therapeutic agents. They see physicians including themselves being placed in the onerous position of not writing prescriptions to meet their patient's needs because there are not funds to fill them.
* Radiological Services have placed limits on the diagnostic services they are able to perform. Funds are just not adequate for supplies and costly equipment maintenance.
* Many bright promising young men and women are appalled as they witness a break in the VA's long tradition of funding clinical investigators and scientists. Even established investigators are having 80% of their requests disapproved by VA Central Office. The VA quite understandable takes great pride in its Nobel Laureates whose works were so generously supported in the 60s. Without more support now there will be no pride in the future.
* But perhaps most disheartening and most hazardous for their veteran patients, orders are now out that outpatient appointments are to be curtailed and those that have to be made should be scheduled as far into the future as possible. Some veterans under these stringencies are going to be lost to follow-up and some will have suffered progression of their diseases beyond the point of no return. Of those patients who do get appointments many wait for hours in clinics because of the sad, chaotic state of medical records and their general unavailability when needed.
* But perhaps most significantly they will have served with a staff of health care providers who each day wonder what next will befall this wonderful system to provide

first-class, high quality care for veterans. They question if we are not moving to a time when the practice of medicine for veterans will validly be regarded as being second or even third-class, merely an alternative to the care of the indigent in the charity wards of public community hospitals.

Can you fault a bright young man or woman physician who plans for a career elsewhere than in the Veterans Medical Program? And that my friends is the challenge which together we face. How to turn this thing around?

And maybe the time of Veterans' Affairs being elevated to the Cabinet level is the time to do it:

* There has to be more money.
* Effective management practices must replace past and present Mickey Mouse travesties.
* Section 4108, Title 38 U.S.C. with its unfettered delegation of authority must be replaced by modern personnel policy structures.
* And, the new Department of Veterans Affairs must have leadership of character and competence akin to that of the Bradley, Hawley, Magnuson triumvirate and the early CMDs who followed. NAVAP suggests that many voices should be heard in the selection process for CMD, with that of the Association of American Medical Colleges being only one of the many.

And now you might ask, if things are as bad as they seem, why even try for a fix? And the answer to that question is that most of what ails the Veterans Medical Program is but a reflection of the larger society in which we live. We need to make every effort to have the VA Health Care Delivery System live up to its prior promise because it has the potential for becoming one of the models which America must have if we are to meet the unmet health care needs of all of our citizens. In our pluralistic society some of its features may be found more attraactive than those of the failing Health Maintenance Organizations of the private sector, the Insurance Companys' Money Machines or the Health Care Enforcement Plans of Corporate America.

And the action needed now should not be delayed until one day, someone is going to be found dying on a street in the Nation's Capital, perhaps having tried to stay alive on a grate on a freezing January night. And in his meager bag of possessions there is going to be that ribbon with the blue -- and the white stars -- and the medal hanging at the end of it. And we will have allowed a guy who may have tried to go to the VA, and he was one of the lucky ones, a guy who won the Congressional Medal of Honor and didn't have a "service-connected" disability. And he was turned away because for him there was no available room at the inn and he'll die on a grate -- the electronic and print media will have a feeding frenzy -- and even Right or Left leaning ducks with only one foot will run from this responsibility.

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By Terry Jemison

WASHINGTON—Waning hospital budgets have been the hot topic in regional meetings conducted by top Veterans Administration officials this summer, with some hospital administrators forecasting a fiscal crisis by fall as they enter the final months of the fiscal year.

Following their meetings with the field, VA medical officials in Washington began discussing a temporary suspension of their workload-based resource allocation methodology (RAM). That would allow them to move funds around the system to provide quick fixes in geographic hotspots where facilities claim to be on a path toward multimillion-dollar shortfalls.

Chief medical director Dr. John A. Gronvall said a small task force is synthesizing dozens of options—reportedly including the RAM suspension or vertical cuts by eligibility class—that have been put forth through the regional meetings with hospital chiefs as well as meetings of various internal and external advisory groups.

Thomas Turnage

He said he would have "prioritized recommendations" to deal with shortfalls this month. "...We'll be in good shape to say here are a series of steps that we think could be taken to harmonize the amount of money we have with program responsibilities," Dr. Gronvall said at one meeting.

Symptomatic of the current atmosphere in Washington to protect the bipartisan deficit-reduction agreement, an infusion of new resources was not promising. The White House budget office reportedly has rejected the medical department request that VA ask Congress for a supplemental appropriation for fiscal 1988 that would bail out some financially strapped Veterans Administration hospitals.

The financial outlook for the next fiscal year, which begins October 1, similarly looks unappealing to VA managers, who blame rapidly escalating prescription drug costs, new programs or benefits authorized by Congress without accompanying funds, and political and legislative requirements that the hospitals maintain certain staffing and bed levels—and in some cases, certain specialized services—at any cost.

The impact is compounded by requirements that VA hospitals absorb pay raises and added health insurance costs as well as arbitrary "productivity gains," which are billed as projections of doing more with less, but actually constitute a 1 per cent annual across-the-board reduction in resource allocations.

VA's top political guard is unsympathetic. VA administrator Thomas K. Turnage bragged publicly about the chilling effect of his site visits to the facilities on hospital directors who are prepared to enumerate their decrements in service, but who begin "covering their tracks" when he interrupts with the administration's message that overall funds and staff levels are up and authorized beds are vacant.

At a recent public meeting of policy advisors at VA, Turnage related such an anecdote of a backpedaling hospital director. "While I'm not a vindictive man," Turnage grinned, "they know I have a long memory."

Turnage's deputy, Thomas Harvey, under questioning by VA physicians following a speech to the National Association of VA Physicians a month earlier, acknowledged that a problem with Turnage's site visits is that career employees tend to tell the administrator what they think he wishes to hear, which fuels Turnage's public pronouncements about the system's health.

However, given an opportunity to speak

out in the press without attribution—through a *U.S. Medicine* survey of field facilities' medical leadership—chiefs of staff said the Reagan administration's message that budgets are adequate because high-eligibility veterans are not being turned away is a red herring.

In many cases the hospital's equipment funds and maintenance and repair accounts have been pillaged to be able to continue business-as-usual patient care, they related (see related story on field survey).

Some congressional leaders this summer were fighting for a supplemental appropriation, while others were skeptical, as the VA "fiscal crisis" is not universally accepted as a fact throughout Washington.

One high-ranking appropriations committee source observed that he has seen no evidence of anything unusual in the VA's fiscal health this summer. Besides, he said, the RAM model by which VA carves up his panel's funding is merely an invention of the VA that can be washed away or modified with a stroke of Dr. Gronvall's pen.

In other words, he explained, VA can act administratively to move money around within the system to take care of any troubled hospitals—"robbing Peter to pay Paul." At authorizing committees, staff members also agreed that such a reprogramming would not require congressional approval.

Further, it is generally acknowledged that the resource formula has worked in tandem with space-available eligibility rules to yield serious inequities in access. For example, two veterans of the same non-service-connected eligibility level may find dramatic differences in availability of care for the same condition if one lives in the Northeast and another lives in the resource-constrained Sunbelt.

A member of one of the authorizing committees who has championed more funds and services for veterans, Rep. Lane Evans (D., Ill.), is squarely in the middle of the rationing dispute and is asking the same reprogramming question.

He has an unusual dual interest in the matter as the chairman of the Oversight and Investigations Subcommittee of the House Veterans Affairs Committee, while also a representative of constituents in the region recently affected by one of the first publicly identified eligibility cuts, at the Iowa City, Iowa, VA hospital (the hospital lies just across the state line from Rep. Evans' Illinois district).

Local VA officials confirmed that 500 outpatients in Rep. Evans' district were affected by the policy change, and while he has been assured that Iowans can be taken care of at Des Moines medical center while his Illinois constituents can receive care at a Peoria VA outpatient clinic, he thinks the case illustrates a fundamental problem of equity in access.

"Veterans benefits essentially are dependent upon where you live in the case of these non-service-connected Category B and C veterans (the two lowest income-based eligibility levels)," Rep. Evans said in an interview.

"...Five hundred veterans living in my district get less benefits than veterans living in another state."

"We're just shifting these veterans from one facility to another," Evans said. "I don't know how that saves us money; it certainly does not provide for real coherent planning or delivery of services to these veterans."

However, there is some sentiment within Congress and in the VA that if a hospital is facing a $4 million deficit in the fourth quarter of this fiscal year, its director probably has not paced his expenditures by controlling workload, such as limiting admissions to only the highest-eligibility veterans.

For example, most non-indigent, non-service-connected veterans have no statutory right to care, and while they may be taken care of on a space- and resources-available basis, systemwide figures (which do not reflect possible geographic crises) for last year show that about 7 per cent of applications for medical care fell outside of this mandatory care category.

Yet at the same time, VA's medical leaders have been vigorously implementing a defensive public relations strategy of discouraging the field hospitals from doing as the Iowa City hospital has done—publicly acknowledging policy moves to ration care to only higher-eligibility veterans.

Some view that as a mistake, believing that acknowledgment of rationing will bring about more political support for initiatives like one recent proposal that would have diverted NASA space station funds to veterans health care.

On the other hand, some VA medical officials fear that setting such black-and-white policies as refusing new appointments to lower-eligibility veterans will never be undone because of their potential attractiveness to the White House budget office.

Given the prospect of tight resources continuing throughout fiscal 1989, the dilemma was at the center of a hot debate within VA's medical department and its Field Advisory Council in July.

What some call a "Washington monument" exercise—a symbolic focus on policies to actively ration care on the basis of eligibility category—could lead to acceptance of the threat on a broad scale, some officials warned.

"I don't want to do permanent damage to the veterans system," Dr. Gronvall said, explaining his aversion to the "Washington monument syndrome."

"I don't want to just go around crying wolf," he said.

The field advisors are looking at a combination of options, such as cuts in medical education support.

"What we've done this year is cannibalize our equipment money and some of our discretionary funds," Dr. Gronvall said. Now those options no longer are available.

"I want to be honest about the context," he told another group of outside advisors at a subsequent meeting, noting that things are tight in the private sector as well.

"I don't want anyone to think we're overdoing the problem."

For the time being, one high-ranking operations administrator told *U.S. Medicine*, instead of announcing broad policies such as "no Category B and C care," hospital directors are expected to put the word out quietly to staff members involved in medical admissions and appointments scheduling, then ration access case-by-case based on eligibility findings.

However, so-called "drop-ins" pose a problem observed by another staff member, who said that once a veteran presents for evaluation and a physician has become involved in the case, patients tend to eke through the best eligibility triage.

For next fiscal year, based on budget marks already sent to the field, a shortfall could amount to between $540 and $800

million systemwide if workload reflects current levels of need coupled with new programs.

Within that figure is $250 million in new but unfunded statutory benefits just added by Congress—including beneficiary travel and nurse pay (see related story)—as well as the anticipated absorption of pay raises, employee health benefits and specified AIDS programs.

Field officials have complained about requirements that they maintain minimum numbers of beds (required by law) and a set number of staff slots, as decreed annually as part of the appropriations process. Medical leaders in Washington, warning these hospital directors that Congress watches those numbers carefully, have been reluctant to allow directors to scale down operations that way.

However, *ad hoc* controls over "quantity of care" may be developing locally in ways unknown by VA medical officials in Washington; an independent mail survey of VA chiefs of staff conducted by *U.S. Medicine* indicated additional facilities—beyond those like Iowa City, Boise and San Diego that are listed officially—are limiting access.

"We have been forced by fiscal crises to restrict care of the non-service-connected patients even past the point of current eligibility regulations," a southern hospital's chief of staff said.

"Why seismically reinforce a VA hospital at a cost of several million dollars when veterans are dying while awaiting at times low-cost needed treatment or restricting drugs as a cost-savings method?" he asked.

While only a few chiefs of staff from among the 41 survey respondents said flatly there is no fiscal crisis (many did not explicitly address the question), most said that whether non-service-connected veterans are being turned away is not a reasonable yardstick of the state of the VA system.

"'Turning away' is a quantity issue," a midwestern chief of staff noted. 'The crisis exists in quality of care.... The crisis we are experiencing reduces our care to marginal, our equipment to old and worn, and methods and experience to inferior."

The chairman of a dean's committee for one VA hospital wrote top VA medical officials in Washington to complain that the agency has refused to allow the affiliated VA hospital to close an organ transplant program—despite VA's rescission of the extra funds it had promised for the program's operation. In general, quality of care at the facility is in jeopardy, the dean of the prestigious medical school said.

Congressional committees have varying levels of empathy.

Rep. G.V. (Sonny) Montgomery (D., Miss.), chairman of the House Veterans Affairs Committee, has strongly advocated a supplemental appropriation. He was so swayed by reports of quality decrements at one facility that he inserted a nurse's plea for more staff in the *Congressional Record*. "The end of the fiscal year is far away," the Ward 7C nurse at an unidentified northwest hospital wrote, "and patients are in danger today."

"On May 19," she wrote, "I worked a 10 1/2-hour shift nonstop. One patient had chest pains.... While I spent so much time with him, the other 21 patients were taken care of by my one support staff. Nine a.m. medications were not delivered to all patients until after noon. One of my surgical patients did not receive a needed dressing change."

"On May 22, only three staff were assigned to care for 36 patients ... One patient had been on the wing for 24 to 30 hours and had surgical dressing ... ordered for each shift. None had been done since he transferred from his old ward the day before.

"He has a colostomy stoma that opens directly into his incision and stool often gets into the wound. I found a patient who had had an IV hung 30 hours earlier. It is anyone's guess when that bag had quit running; his arm was red and painful...."

A senior physician at the same facility contacted by *U.S. Medicine* voiced similar concerns. "Waiting for the system to fail is too late because there is a long lag to fix it, and when it fails, eligible vets will go without services.... We simply don't have the money to give critical life and death care in some instances."

The VA medical department's Field Advisory Council reportedly suggested that Dr. Gronvall consider policies to manipulate workload in part using the eligibility screening opportunities presented by the new VA patient "means test" as at least a partial solution to budget deficits.

Under law, VA is required to furnish hospital services to service-connected veterans and to non-service-connected veterans whose income is less than $15,833 (or $18,999 for a married couple). The other non-service connected are categorized into two other income brackets, the higher of which involves copayment.

Rep. Evans said he is concerned about what this summer's fiscal problems at certain hospitals portend for the future of VA health care.

With VA "struggling to tread water in terms of current level of services," how will it meet the steep demand curve approaching with the aging World War II veteran? he asked.

In an earlier statement at the time of the Iowa City cutbacks, he published a news release in his local district, asserting, "This is nothing but an attempt to balance the budget on the backs of the veterans."

Several days later, VA administrator Turnage responded that the "desperate voices" complaining about balancing the budget on the backs of veterans "are the same guys who voted for the compromise...for this year's budget arrangement."

Criticizing the exploitation of a local dispute for political purposes, Turnage said the nation needs more statesmen and fewer politicians. "I think it's political garbage," Turnage said. "I find it reprehensible."

Rep. Evans said it shows why VA needs Cabinet level status, to reduce the political leverage instilled in the agency by White House budget authorities.

"Why is there a summit agreement?" Rep. Evans asked. "Because of Gramm-Rudman. I'm a member that did not support Gramm-Rudman originally because I thought it would lead to this kind of situation in which important programs like this one are forced into...cutbacks."

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Quality Worries VA Chiefs Of Staff

(First in a series)

WASHINGTON—A U.S. MEDICINE survey of chiefs of staff throughout the Veterans Administration medical system evidenced significant concern about erosion in quality of veterans health care.

"We are being slowly strangled to death," a Midwest chief of staff summarized.

VA The State of The System

Quality is jeopardized by an inability to replace a broken bronchoscope or sigmoidoscope and an inability to offer salaries needed to retain excellent doctors, nurses and medical administration clerks, the chiefs of staff said.

Basic supply needs are not being met in some locations, with expensive drugs sometimes out of reach—or long delays for procedures that require special supplies, such as joint replacement or lens implant after cataract surgery.

For others, the fiscal squeeze means inadequate funding for halfway houses for effective substance abuse therapy or barriers to outplacement of veterans requiring extended care.

Even in the hospitals where the medical leadership felt resources were adequate, there is a nagging concern about such areas as decreasing opportunities for continuing education.

Forty-one chiefs of staff responded to the survey, representing about a fourth of VA's 172 hospitals.

Many showed political sophistication in their understanding of the dynamics of policy change, such as the New England chief of staff who forecast, "Congress will not deal—on its own—with the issue of progressive horizontal cuts versus restructure of the system through vertical cuts (in hospitals and programs). This failure will place the system in great jeopardy because it will create a perception and reality that the VA is 'not as good' as the private sector."

He proposed a 17-point plan to deal with expectations that Congress will not provide appropriations beyond an inflation-adjusted 1977-comparable level; he suggested such moves as a campaign to convince Congress that an emphasis on beds is destructive and a medical department initiative to shrink the system based on maintenance of quality of services.

A Western chief of staff said decrements in quality are visible not just in clinical errors but also in missing charts and lab reports, as well as "...long waits (and) very long periods between clinic visits to accommodate greater numbers of patients with concomitant deterioration of proper patient followup."

A Midwest chief of staff said his pessimism is reflected in unfunded equipment needs exceeding $1 billion systemwide. "In economically depressed areas, VA health care is the only health care available, and this safety net now has many holes, is frayed at the edges, and is in danger of collapse," he wrote.

On the other hand, numerous other facilities did not forecast "gloom and doom," though few if any were consistently upbeat about the trends they are observing.

Several other patterns—to be examined in future issues of *U.S. Medicine*—also emerged from the survey of the state of VA health care: the medical district planning program engenders enormous hostility ("a joke," "a sham," "dominated by the regional director's lay staff"); the resource allocation methodology (RAM) funding formula, while often suspect, has both champions and critics, the latter alleging widespread gaming and abuse of the process; and chief medical director Dr. John A. Gronvall enjoys wide respect for making the best of a perceived no-win situation of conflicting pressure from VA political appointees, the White House, the Congress, and veterans groups.

The survey was designed to stimulate narrative and suggestions, and thus did not yield statistically quantifiable yes-no views of the budget, yet certain areas of consensus were suggested. For example, chiefs of staff surveyed frequently contested the premise held by certain political defenders of current budget request levels that funds must be adequate if eligible veterans are not being turned away and if significant amounts of care are being devoted to non-service-connected veterans.

Many respondents noted that most of the non-service-connected veterans cared for are in the lower economic bracket for whom VA is required to provide care.

While VA has for years used the adjective "eligible" in cloudy policy statements such as "no eligible veteran has been denied care for agent orange-related disease," the chiefs of staff surveyed frequently sought to clarify the administration's contention that no eligible veterans are being turned away from VA hospitals.

Recognizing statutory distinctions of eligibility categories between when VA *shall* provide care and when it *may* offer care, one Southeastern hospital's chief of staff brought the matter into clearer focus this way: "*Obligatory* eligible veterans are being treated, but non-service-connected, seriously ill, poor, combat, *eligible* veterans are turned away daily."

"We are not, unlike most other sections of the country, able to provide outpatient care to veterans other than those who are

"entitled by law and those who require follow up treatment for recent hospitalization," he explained.

"There appears to be *absolutely no interest* in VA Central Office, the Congress or the White House to attempt to offer or deny treatment to veterans even-handedly throughout the country. We daily turn away veterans who have been treated for years at northern VA hospitals," he added.

He pleaded for leaders to insist that Congress and the executive branch "define *what* they want done to whom and where." Programs, eligibility and treatment sites, he said, "must be adjusted down on a need, not political, basis."

Yet a Northern hospital's chief of staff also recounted serious resource constraints. "I have seen denial of services to non-service-connected veterans and shuffling and shunting of service-connected veterans to tertiary care hospitals for lack of timely replacement of common diagnostic equipment such as echocardiograph, EEG, etc.—fiscal crises plenty during the last three years."

Even the calmest voices are concerned that adapting to fiscal austerity has sometimes not kept clinical priorities highest, taking a toll in equipment resources and medical education as well.

"Crisis? No. Limitation in spending and conserving resources? Yes," the chief of staff at a Midwest hospital said.

"We have an elegant new fire station and are remodeling or removing the greenhouse when we need to have a clinical improvement addition and ward remodeling, which keep getting delayed."

Another Midwest chief of staff said his facility has been able to care for all veterans applying for medical care, but not without a price.

"The staff of the hospital has been working harder and harder, solely to treat patients," he said.

"They have had to give up time that could have been devoted to clinical research and to academic pursuits.... Teaching medical students and residents has been eroded, ever so slightly, but noticeably over the past three years."

While most rejected the idea that admission rates for low-eligibility patients are a good yardstick for measuring fiscal health, a mid-Atlantic region chief of staff said only about 20 per cent of his inpatients are service-connected veterans, and only about 4 per cent are in the hospital for their service-connected problem.

Another chief of staff who had seen no evidence of fiscal crisis sympathized with hospital directors who must spend money "within its category," noting he has seen wallpaper placed over marble.

"We cannot spend 'construction' money for 'patient care' programs; thus, they have to do something with it," he commiserated.

Even those who were least concerned about the fiscal health of VA medical care still said opportunities for continuing education and travel funds for meetings were woefully inadequate, although others said the resources are made available through the facility's academic affiliation.

"The fiscal crisis is of major proportions," a Midwest chief of staff wrote, away entirely, both the range and the quality of service has diminished as funding has become limited.

"Some kinds of surgery are no longer being done, new diagnostic and therapeutic techniques are not being introduced widely, obsolete equipment is not replaced, deteriorating physical plants are not repaired, and almost all capital funds—equipment, construction, etc.—are used to support operating expenses."

Another Midwest facility's chief physician called the budget process a national disgrace because of approval delays that impair hospital planning.

"Numerous plans for improvement of delivery of care (needed nurse specialists, IV teams, improved escort services, adequate psychotherapy services, updated equipment) cannot be developed due to lack of funding or nebulous FTEE ceilings," he said.

A New England facility's chief of staff said few veterans in need of hospitalization have been turned away without a place in the community after a "determination of need for hospitalization," but there are signs of fiscal crisis, he maintained.

"Many of our scheduled clinics are backed up from two to six months. Hip and other joint replacements are delayed six to nine months because of lack of funds to pay for the prosthetic devices.... "

A Southern hospital's chief of staff said his staff was harried and fatigued from recruitment and retention problems due in part to funding shortages and in part due to unimaginative personnel policies.

At a West Coast hospital, the chief of staff said the capital base is being undermined. "You cannot continue to take productivity cuts year after year without eventually stripping away muscle as well as fat and eroding morale.

"Our needs for equipment and construction are becoming critical. At some point, there will have to be a 'catch-up' period. The same is true of federal salaries."

The fiscal crisis is reflected in a six-month waiting list for orthopedics, another Western hospital chief of staff said. A Midwestern facility's medical chief said he feels the pinch in an inability to order fee-basis care when needed.

"I have noticed new carpeting in the administrative suite when patient care facilities went wanting," a Midwestern chief of staff said. Yet another medical chief in a neighboring state observed, "Construction funds are separate from medical care. We have to keep up our properties, but people do not understand these mechanisms."

At a Northeastern hospital, the chief of staff said physician turnover is a good yardstick of resource needs, acknowledging his facility has imposed stricter medical need criteria for admission, has sicker patients, and a shortage of psychiatrists.

"The staffing shortages are worst in psychiatric care areas," a mid-Atlantic chief of staff agreed, "which is ironic since the VA provides 50 per cent of all the inpatient psychiatric care received by veterans in the U.S., a higher percentage than for medicine and surgery."

In general, he added, "Current staffing levels in VA facilities are below comparable university hospitals and below most public sector hospitals."

As did several of his colleagues in the South, one chief of staff voiced frustration about variance of access between geographic areas. "Many eligible veterans including service-connected are turned away in Region 3, (a) rationing of care," he said.

"The resources are probably at least $400 million short for the system to maintain current services," he said.

(NEXT: Resource Allocation Methodology)

(Second in a series)
By Terry Jemison

WASHINGTON—Concern about waning medical budgets at some Veterans Administration hospitals has grown serious enough to prompt oversight hearings in Congress this month.

Some physicians are preparing to use the hearings to focus part of the blame on VA's "resource allocation methodology," or RAM model, which determines how the federal budget sum for VA medical care will be divvied up among veterans hospitals. Panels of both the House and Senate veterans affairs committees are expected to examine the hospitals' budget situation in separate hearings.

One prospective witness said he will tell Congress the RAM is a failure encouraging "sicker and quicker discharge of veterans...and the creation of a reference for admitting, treating, and discharging patients that replaces the only valid reference, namely, 'what is best for the patient?'"

Another VA field official said the RAM formula has been manipulated repeatedly to protect "flagship" VA hospitals while making geriatric and psychiatric care more difficult in the rest of the system. Some believe tertiary care is penalized because of the absence of a severity illness, and numerous chiefs of staff at various VA hospitals appear to share frustration that there is little return for productivity as the overall pool of inflation-adjusted money appears to dwindle.

Peppered with acronyms like WWU, RUG, DRG, and LOS—along with statistical concepts like trim points—the RAM itself did not lend itself to much congressional attention as its controversial formula for slicing the budget pie evolved in the last few years. Groups such as the National Association of VA Physicians (NAVAP) have been disappointed that veterans service organizations, like Congress, have been relatively silent on the effects of the RAM on patient care.

"These times cry for aggressive and effective leadership and management," NAVAP executive director Dr. Paul W. Schafer said. "Instead, we have DRG (diagnosis-related group) RAM, a completely predictable failure—what would seem to be an unfulfilled agency death wish which now appears to be in its last agonal convulsions."

Many VA officials support the RAM concept or its results as an improvement over the historical-cost system on which budgets previously were based. For each dollar "lost" by a northeast psychiatric hospital, for example, there is a "gainer" hospital somewhere, probably in the Sunbelt, where officials previously complained the old budget system was not keeping up with the growth of demand.

Further, the General Accounting Office, in a report published last year, found that while the RAM evolved amid problems with questionable data and field concerns that the burdens of care for psychiatric and AIDS patients were not treated validly, it still is a significant improvement over its predecessor methodology.

The GAO relied on VA documentation and testimonial evidence on RAM's intended operation, but the congressional agency did not validate the extent to which RAM accurately measures workload as VA intends or actually performs as expected. Conceptually, GAO applauded VA's efforts at "matching costs with outputs."

"The methodology should heighten the sensitivity of field managers and direct service providers to the appropriateness of the services and the cost of providing care," GAO concluded.

However, less than a year later, a survey of chiefs of staff at VA hospitals around the country indicated that much of the dissatisfaction with the RAM is in its administrative burden and influence on hospital directors to press for the production of weighted work-units (an increment of workload measure), a burden some liken to an army of "green eyeshades" employed by directors to "outfox the foxes," as one chief of staff put it, to ensure their hospital gets maximum return.

At a Northwest hospital, the chief of staff complained that the RAM rules are changed in Washington on a whim. "It is gamed to death," he wrote, "taxed to death and *will* be the death of tertiary medical care in the VA."

The pressure to turn out weighted work units has not only driven trends applauded by VA officials, such as increasing emphasis on outpatient care, but it also has led to what some consider an extraordinary amount of attention to "gaming" the system.

"The driving emotional force in all of this charade," Dr. Schafer of NAVAP said, "is the sense of guilt created in the players, those who bore the stigmata of not having done their best, particularly in those who were actual WWU-over-dollar losers.

"This DRG-RAM management disaster has now been in place just long enough, finally, to be recognized for the damage it has caused, not the least reason being the precious scarce funds for patient care which facility directors, regions, and Central Office have diverted to DRG-RAM administration...."

The cost of "DRG-RAM gamesmanship," he said, is measured in decremental funding for supplies and equipment, fewer operating hospital beds, delays for patients, and less ambulatory, intermediate and nursing home care.

A *U.S. Medicine* survey of chiefs of staff around the country found such views were not uncommon, but far from unanimous.

"The problem," one Southern chief of staff said, "is that the dollars to support this increased revenue (from increased workload) are not available, and the revenue reward is then decreased by realigning the weighted work units to match the dollars."

A Region 5 chief of staff was more succinct: "The RAM is truly an Alice in Wonderland methodology, an unverifiable nightmare creating utter chaos in the field."

A Midwest facility reported that RAM started off well, improving efficiency, but has degenerated into "a disaster," with the chief of staff there observing, "A mechanism for addressing the problems of facilities harmed by RAM methodology is wholly inadequate if not nonexistent."

"It is a zero-based system where inadequate total dollars are redistributed among VA hospitals," a region 6 medical staff chief said.

Another region 6 chief of staff at a Northwest hospital went even further. "The RAM is a joke. It is poorly thought out, changed on a whim, has so many adjustments to try and fix its shortcomings that it is unintelligible."

Others had a different view, such as a third Region 6 medical chief, who said it

is an improvement over the historical cost system, though its main drawback is the cap, or limit, on the flow of resources between medical centers.

"RAM would be okay if done properly," a mid-Atlantic chief of staff said, "but cuts are made by RAM plus withdrawals by Central Office for other reasons.... RAM does not consider severity of illness, so tertiary hospitals are at a disadvantage."

Additional mixed feelings were shared by a Southern hospital in Region 3, where the chief of staff said it is superior in equity to the old system, but it is significantly underfunded, and while it redistributes money from large hospitals, "it is somewhat blind to small, very active hospitals."

The Region 3 chief of staff at another Southern hospital wrote, "RAM is a decided improvement over the old self-serving system, but it is only an intermediate step to the fiscal solution of independent patient billing based on cost. The RAM task force should now concentrate their efforts on a capitation method of resource distribution."

The old system basically was comprised of "head counts," a Midwest chief of staff said.

"The RAM is an improvement," a Western chief of staff said, "primarily in the fact that it is forcing all participants to address proper use of funds and to show results, i.e. workload."

A Southern hospital official said RAM is an improvement, "but was put into place without adequate testing...(and) is severely underfunded, leading to cutthroat competition and gaming."

A Midwest chief of staff had similarly mixed reactions. "RAM appears a viable and logical system of funding," he said. "The 'formula' is totally ridiculous, however, in that with all the tampering and adjusting, the entire methodology becomes a sham without logic or fairness. The old cost system was better by comparison."

"Resource allocation is a joke," another Midwest chief of staff said. "Hospital staff who work hard and efficiently are not rewarded for their effort. A cap is placed on their profits, thereby making it impossible to hire more people."

"The RAM is unrealistic for much of the chronic illness, rehabilitative programs and psychiatric problems confronting the veteran population," a mid-Atlantic hospital chief of staff said.

He maintained the DRG system (in which RAM shares a basis) was developed for patients in small community hospitals for whom family backup and care is more readily available on discharge.

A Western chief of staff in Region 7 agreed. "With the various legally mandated care for certain patient categories, the DRG is not suited for VA use. Shrewd maneuvering and gaming are necessary to survive."

A mid-Atlantic chief of staff observed that quality of care is suffering under RAM. "Many medical centers are seeing more patients and doing more for them, yet finding they are still losing in ensuing budgets as the dollar generated per weighted work unit decreases....

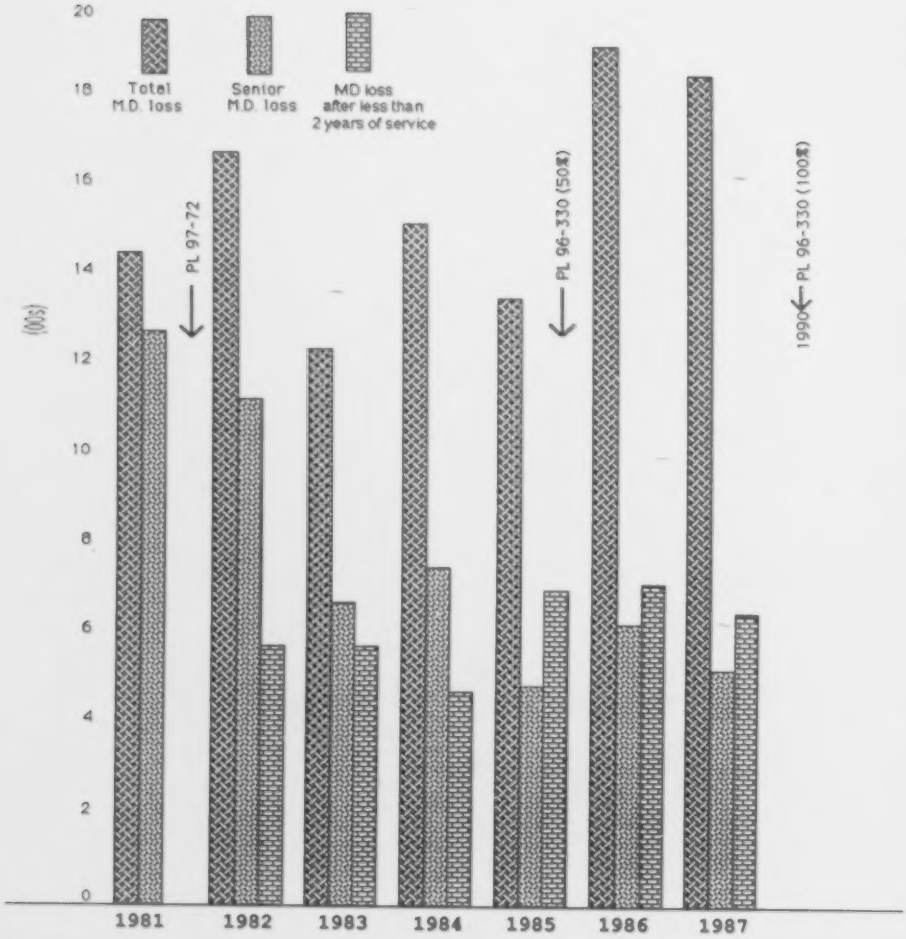
"Large metropolitan medical centers appear to have more longer-term placement problems and greater difficulty competing for nurses, health care professionals and clerical staffs, hence higher salaries (special rates) which aren't adequately compensated for in the RAM model."

"The game has gotten to the point where subversion of the system to become a winner has become more important than patient care," a Northeastern chief of staff said.

A Midwestern chief of staff agreed. "Much effort is expended in adapting behavior to maximize RAM reimbursement; when the RAM drives efficiency and good care, this is fine, but where time is wasted on RAM analysis rather than efficiency *per se*, scarce resources are wasted and the focus is backwards."

While RAM is an improvement over the historical method, a Midwest chief of staff said, the two-year lag between workload and reimbursement "severely penalizes growing medical centers and rewards those that are shrinking."

However, a Northeastern facility's chief of staff said the historical cost system was better. "The RAM benefits large/complex VAMCs. The small, rural VAMCs are negatively impacted by the new grouping refinement under the RAM."



VA PHYSICIANS
WHO HAVE LEFT THE SYSTEM

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

TESTIMONY

Of The

AMERICAN NURSES' ASSOCIATION

AND

ASSOCIATION OF OPERATING ROOM NURSES

On

VETERANS' ADMINISTRATION

HEALTH PERSONNEL AND POLICY ADMINISTRATION

Before The

HOUSE VETERANS' AFFAIRS COMMITTEE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

PRESENTED BY

GLORIA HOPE, PH.D., R.N.

SEPTEMBER 7, 1988

1101 14th STREET, N.W., SUITE 200, WASHINGTON, D.C. 20005 — 202-789-1800

Mr. Chairman, I am Gloria Hope, Ph.D., R.N., a retired Veterans' Administration (VA) nurse, who previously served as Deputy Director of the VA Nursing Service. More recently, I retired as the Director of the American Nurses' Association (ANA), Department of Governmental Affairs. I would like to thank you on behalf of the 188,000 members of the ANA and its 53 constituent state nurses associations for this opportunity to address veterans' health issues, and health personnel related matters. I am also pleased to appear today, on behalf of the approximately 40,000 registered professional operating room nurses who are members of the Association of Operating Room Nurses (AORN). A significant number of our members are VA nurses. ANA has represented VA nurses in collective bargaining since 1967 through its state nurses' associations.

This hearing reflects the committee's continued commitment to the provision of quality health care for the men and women veterans of our nation. The committee has been instrumental in improving working conditions for nurses, guaranteeing nurses the right of collective bargaining, encouraging nursing career development, providing educational opportunities, promoting clinical nursing research and fostering the critical inclusion of nursing within the Veterans' Administration health care system. Those policies have done much to assure quality nursing care for veterans.

ANA and AORN would like to thank the committee for the passage of several provisions of Public Law 100-322 which enhanced the ability of the VA to recruit and retain nurses. Your continued efforts demonstrate the committee's recognition of the seriousness of the VA's nursing shortage, its effects on veterans' health care, and the need for long term solutions to address the problem.

After several years of staff reductions, a trend has emerged in the health care industry: a shortage of registered nurses. Today, hospitals across the country are reporting numerous budgeted nursing vacancies. The vacancy rate has more than doubled between 1985 and 1986 (from 6.3 percent to 13.6 percent) according to data released by the American Hospital Association (AHA).

Current payment policies by the federal government and the private sector are creating situations in which patients are generally admitted only for the acute portion of their illness. While in the hospital, the average patient is more acutely ill than in past years, and requires a more intensive level of nursing care. This has placed an additional demand on nursing staff, who are now required to have far more sophisticated skills to perform physical assessments, monitor and utilize high technology equipment, teach patients and their families, and prepare discharge plans.

Some hospitals overreacted to Medicare's Prospective Payment System (PPS) by cutting nursing budgets, laying off nurses, and halting recruitment efforts. Many of the nurses who were terminated moved to other settings and positions, thereby reducing the supply of nurses available to hospitals. Hospital executives are now acutely aware that nursing staff levels are grossly inadequate. ANA and AORN believe that, as a result of these developments and trends, the average workload of registered nurses has increased markedly, and has been responsible in part for the emergence of the current shortage of registered nursing personnel in this country.

The nursing shortage is critical because people in need of nursing care are seriously ill. Their care is complicated by factors of age, the presence of

chronic illnesses affecting many body systems, the use of highly technological treatments, pressures for early discharge, and the rapid increase in the number of patients with acquired immune deficiency syndrome (AIDS). Veterans who require health care are no different than those who seek care in the private sector.

The surging demand for nurses, a major factor in the shortage, provides evidence that efficient, effective utilization of qualified, experienced registered nurses is needed to preserve quality of care within the limits of cost containment. ANA and AORN believe it is imperative that any solutions initiated to resolve the nursing shortage be directed toward the root of the problem, with careful consideration to the cost and quality of health care delivery and the changing needs of the health care system.

In order to alleviate the immediate shortage, ANA and AORN endorse the following two short-range strategies:

1. Immediately increase the time that registered nurses spend with patients by reallocating resources and developing staffing to:
   - o employ nursing assistants and licensed practical nurses (LPNs) to assist registered nurses (RNs) in the support tasks essential to patient care;
   - o change the salary and benefit structure to retain experienced nurses; and
   - o help nurses who work part-time to return to full-time employment.
2. Quickly expand the overall pool of registered nurses who work in hospitals and long term care facilities by:
   - o facilitating the educational mobility of LPNs and aides;

- increasing financial aid to career changers to complete accelerated RN programs;
- increasing financial aid to minority students; and
- increasing the number of work study programs.

The needs of patients in today's health care system require the care of a registered nurse. The nursing profession is committed to these short-term strategies to alleviate the shortage of registered nurses, while it seeks long-term solutions to address the expected future need for nurses.

A shortage of registered nurses also often leads to inefficient use of hospital facilities. In some hospitals, for example:

- Patients are refused admission to intensive care units;
- Patients are admitted to intensive care units because of a shortage of medical/surgical nurses to provide care needed in those areas;
- Patient transfers may be delayed;
- Patients may miss, or be incompletely prepared for, diagnostic tests; or
- Hospitals may be forced to close beds/units to admissions.

Years ago, VA hospitals were in the forefront with respect to nurses' salaries, benefits, and educational and professional development. However, as the private sector responded to changes in medical reimbursement, patient acuity, and health care manpower concerns, the VA has been unable to compete. Nowhere is that more evident than in nursing recruitment and retention.

ANA and AORN have observed many of the same patterns of difficulty throughout the VA's national medical centers. For example, the VA hospitals in

the Atlanta/Augusta area have closed 125 patient beds because there are not enough nurses to provide care to veterans requiring hospitalization. The Manhattan VA had to limit its cardiac surgery due to a shortage of critical-care nurses. In addition, the Togus, Maine VA had to close a ward because of the nursing shortage.

The VA medical systems in Boston, California, and the District of Columbia (D.C.) have had to utilize agency and per diem nurses. In areas such as the Bronx where a concerted effort exists not to use agency nurses, the costs for overtime have dramatically increased. VA medical centers in California reportedly may not have the option of overtime because of staff complaints of burn-out.

Inadequate staffing means that several VA hospitals in New York, Boston, D.C., and California have been unable to fully staff critical-care units. One critical-care respiratory unit has been permanently closed and another has combined its medical intensive care and coronary care units. Still others have closed beds. A New York facility closed two wards because it was unable to meet patient care.

The effects are not felt solely in acute care facilities. A New York VA cannot fully admit to its nursing home. In California, one nursing home with a 120 bed capacity must be limited to 95 patients. Ironically, another VA nursing home is to be constructed nearby. We wonder how they will staff the facility.

In those areas where the number of patients with AIDS has increased, psychiatric units are experiencing manpower difficulties. The medical needs of psychiatric patients have increased in number and acuity. Nursing service cannot

supplement psychiatric nurse staffing to meet patient care needs. A significant number of AIDS patients need one-to-one care because of depression and dementia, and cannot be therapeutically cared for in traditional group settings.

Although nursing executives state that they may have 30 applications for every clinic nurse vacancy, that does not mean clinics are unaffected. Those 30 applications are from in-patient care unit nurses who desire better hours and stable patient acuity conditions. Additionally, we have heard reports that some veterans are experiencing delays in clinic appointments. Baltimore area VA clinics report a 2-3 week waiting period. The admission emergency care units report patient waits of 3 to 4 hours in order to be seen or to have laboratory work done. Nurses are questioning whether staff shortages and increased patient loads will affect future clinic policies and cost allocation. We understand that some facilities are re-examining patient eligibility for clinic treatment and the maximization of outpatient visits.

VA nurses cite several policy and administrative problems as pertinent to these difficulties in providing patient care. Most stress the VA's inability to be competitive with the private hospitals in surrounding areas. In Boston, nurses who leave the VA can make an additional $10,000 or more in the private sector. Although special rates are given to registered nurses, licensed practical nurses, and nursing assistants, manpower problems still exist. Medical centers are unable to fill ward clerk vacancies, which requires the nurse to assume those clerical duties. VA nurses in California are requesting more support staff so they can nurse patients and not answer telephones and process requisition and laboratory forms.

Nurses in the New York area VAs make $3,000 to $4,000 less than the

prevailing private sector community wage. Additionally, VA nurses point out that they have to pay medical benefits, that no child care exists, and that the VA wages do not reflect cost of living demands in areas such as New York, the District of Columbia, Boston, and San Francisco. In some areas, the nurses' salaries are at the end of the pay scale, something which the VA and the Office of Personnel Management have not anticipated.

Associate or head nurses in some area VAs have been excluded from pay raises. The VA stands to lose experienced qualified nurses at the upper levels. Many nurses believe it is better not to be promoted to positions of increased responsibility unless there are concomitant pay raises. Others leave the VA for other positions where they can be financially rewarded for their professional advancements.

VA pay and personnel policies cause other problems. The Baltimore VA has over 80 beds closed, including three to five of critical care beds. D.C. has 70 beds closed. Closed beds are opened depending upon the ability to obtain agency nurses. The irony is that the budget deficit mandated decreased utilization of agency nurses. However, an increased reallocation of funds to assure open critical-care beds still cannot provide adequate staffing. Agencies cannot fill the VA's demands because of their own shortages, increased salary rates, and recruitment problems for the VA. Even if the VA renegotiates agency rates, which will increase its budget allocation needs for such nurses, there may still be unopen critical-care beds. Agency nurses complain of the patient workload of one registered nurse to three critical care patients. The professional standard recommends a one-to-one ratio.

Special rates have not totally addressed the ability of the VA to compete.

Special salary rates continue to lag behind, as they are based on an average which is determined after a wage survey occurs (a three month process at best). The private sector recently raised salary rates in the Baltimore area after a private nurse recruiters' salary survey, but the VA will be unable to respond accordingly until January because of budget restrictions. By then the private sector will have undergone another adjustment.

Nurses who must work additional hours to meet cost of living demands have their earning capacity curtailed by VA personnel policies regarding overtime limits and prohibition of outside professional work. The VA restricts overtime to a cap of $20.00 per hour which could mean that a full or intermediate level nurse who works overtime can only make an overtime rate of an entry level nurse in some geographical areas. Nurses are encouraged to leave, or not enter, the VA because they cannot work as nurses elsewhere during their off time. Some VA chiefs of nursing complain that they are seeing increased conversions from full-time to part-time employment because it allows nurses to "moonlight" outside of the VA. One nurse wrote that it is incomprehensible that she can work as a belly dancer after VA duty hours, but not as a nurse.

Nurses are complaining about the lack of in-service programs and continuing education. They are unable to identify whether the deficiency is due to budgetary concerns about staffing, scheduling, problems or misdirected priorities. They were pleased when tuition reimbursement and bonuses were authorized recently by Congress, but the fact that actual funding has not yet materialized has dampened their expectations.

Nursing is further frustrated when it is given certain Full Time Equivalent

(FTE) positions to staff. There is no real control over staffing when personnel budgets do not match personnel ceilings and neither of these reflects patient acuity and needs. Some VAs have resorted to reducing personnel ceilings to camouflage the shortage of nurses and other staff.

Budget deficits have affected other services besides nursing. Many VA medical centers have given nurses higher salaries, then cut back on support staff e.g., clerical, dietary, and housekeeping. One area VA has one ward clerk for the entire hospital on evening shift and none for nights or the weekends. That same hospital has no full pharmacy coverage. On evenings and the weekends, nurses must mix their patients' intravenous medications.

Reductions in housekeeping staff have had an impact on patient care as well. Nursing staff must clean up spills and make discharge beds to ensure patients do not sit in the hall awaiting a bed. High patient turnovers tax the reduced housekeeping staff's ability to ready beds for patient use.

Medical supplies have also been affected, particularly at the end of the month or quarter. For example, no paper towels were available for nurses and patient rooms at one center. The critical-care unit ran out of central venous lines, necessary for fluid replacement and cardiac monitoring. The increase in patients infected with human immunodeficiency virus (HIV) has also affected the supply budget. Implementation of universal precautions to protect health care workers from exposure to HIV and hepatitis B had overburdened some budgets for medical supplies.

Although chiefs of nursing try not to deny vacations or education leave

requests because of staff demoralization, during the summer peak vacation months nurses have been requested to schedule vacations to accommodate staffing and patient concerns. Unlike private hospitals which can divert patients, VA facilities do not have that option. Therefore, they are receiving more acutely ill patients from the private sector as Medicare length of stays are exhausted.

We would like to offer the following views regarding VA health care policies and administration to the subcommittee. Since a VA chief of nursing has indicated that nurse retention is directly related to workload, tuition reimbursement, and continuing education, these issues must be addressed.

Workload has been identified as a key factor. The VA must furnish the support staff necessary to permit nurses to practice nursing and provide patient care. Patients cannot bear the expense of nurses who cannot appropriately monitor their intravenous fluids, administer medications, and assess their response to treatment because they are tending to clerical or housekeeping duties. Patient care is compromised by nurses exhausted from excessive overtime. Patient-nurse ratios cannot be violated on a continuous basis either in critical-care or medical-surgical units.

We are especially concerned that new health careers may be seen by some as an answer to the nursing shortage. Introducing a new breed of health worker will only create more confusion, as well as accountability and liability problems, without addressing the real need, which is improved compensation and better support systems for nurses. Nurses, who best understand their practice settings, must be centrally involved in defining and developing those systems.

The VA presently uses nursing assistants and licensed practical nurses to

assist the registered nurse in providing care to patients. The utilization of support staff has meant delegating nursing care functions. Additionally, some treatment functions previously administered by nurses have been assumed by technicians.

Differentiating between levels of practice for the purpose of better utilizing nursing personnel is a very sound management principle. Moreover, changes in health care are requiring more of nurses, which the profession has both anticipated and responded to in setting new standards for practice. The nursing shortage is caused in large part by the surging demand for nurses who possess the versatility, organizational ability, and breadth of clinical knowledge and judgment to operate in today's fast-paced, high acuity, and complex health care environment. This must be viewed as a compliment, not a condemnation of the way nursing is practical today. If anything, nurses are the victims of their own success, in that they provide a much needed, though substantially underpriced, service.

However, ANA and AORN believe that any future development of new health practitioners may result in increased fragmentation of services. Better coordination of services is required due to acuity of illness, chronic needs, and discharge planning. Patients may feel alienated by increasing numbers of providers. The professional nurse, more than any other health care professional, is qualified to provide comprehensive, cost-effective, and compassionate care by individualizing and coordinating patient needs with existing multi-disciplinary providers. However, increasing the types of providers will only serve to increase intervenors in the patient care process, which may decrease efficiency. Supervisory requirements of such personnel will increase managerial and planning workloads. With these considerations in mind, we believe appropriate support

staffing for nurses is critical to ensure adequate nurse staffing and quality care. Nursing must have authority and involvement over any individuals performing nursing functions. What the VA system needs is more nurses with adequate support, not any new, lesser skilled practitioner. Any other approach will shortchange our veterans.

The VA administrator must make it clear to Congress that the agency must have monies appropriated to meet ceilings for personnel and administration of programs. The funds for the recruitment and retention of nurses such as tuition reimbursement, bonuses and day care centers must be allocated.

ANA and AORN believe the VA's Nursing Service has the professional knowledge and experience to determine what is appropriate for nursing practice in the VA. ANA urges the administrator to provide adequate levels of funding and administrative support and direction to allow nursing to implement its programs.

ANA and AORN would like to thank the subcommittee for establishing a tuition reimbursement program for nurses pursuing courses leading to a baccalaureate or an advanced degree in nursing. The federal government predicts that by 1990, the demand for baccalaureate-prepared nurses will exceed the supply by 340 percent. The projected shortfalls by the year 2000 will be even greater. If these projections come to pass, it is obvious that a critical shortfall in registered nurses prepared with baccalaureate and higher degrees will be upon us before the next century.

Between 1980 and 1986, the percentage of baccalaureate nursing students studying full-time increased by 12 percent while those studying part-time increased by 114 percent. This trend complements national statistics that report

fewer than 50 percent of all college students are completing their baccalaureate programs in four years. Nearly 25 percent require more than five years to achieve the baccalaureate degree (no doubt the necessity to remain employed while attending school because of the decrease in federal financial assistance has contributed to this situation). The data suggests that a much longer time than the traditional four years will be required to educate a baccalaureate-prepared nurse in the future. Therefore, ANA and AORN believe that tuition reimbursement will help to ensure an adequate supply of appropriately educated VA nurses to meet the expected health care needs of the veteran. We urge the VA to seek continued and appropriate funding for such tuition reimbursement programs.

ANA and AORN support the enhancement of the VA's authority to recruit and retain certain health care personnel. We also support the recent extension of the VA Health Professional Scholarship Program to any field of training or study in direct health care services. We believe that adequate numbers of the multi-disciplinary team are necessary to ensure that nurses can function appropriately to provide quality nursing care. All too often, as demonstrated above, nurses must assume the role of other practitioners to prevent a deficit in patient care. WE expect that the VA's commitment to funding nursing scholarships will not be diminished by such expansion.

The VA must review its policy regarding professional "moonlighting" to allow VA nurses parity with those in the private sector. The agency should also consider increasing the overtime cap.

ANA and AORN recommend that all registered nurses be added to Section 4107(g)(3), which allows certified registered nurse anesthetists (CRNAs) and licensed physical therapists (LPTs) to be exempt from salary limits. In order to

be competitive, hospitals may horizontally extend pay steps from 10 up to 19. The VA must remain competitive. There are currently 14 hospitals which have nurses who are locked in at that top salary step. In the Boston area, the entry level nurse who is topped at $26,000 could make $31,000 in the competitive private sector. The VA must have the authority to allow those nurses to be paid in excess of step 19 as provided in Section 4107 for CRNAs and LPTs.

ANA and AORN would like to point out that VA nurses are not unique in the federal government. Recruitment and retention problems exist for nurses in other federal services such as the Public Health Service, the Indian Health Service, and the Department of Defense. Although all of these are examining the problem and developing and implementing solutions, we believe something else must be done.

While we recognize that this committee has no jurisdiction over OPM and that nurses are under Title 38, OPM has the responsibility of classifying and establishing standards for professional nurses and Title V nursing service personnel and, therefore, patient care in the federal government. We believe OPM could be more effective and responsive to the health care demands of government health care systems, if it employed a nurse at the policy level. Logic would dictate that if you are doing classifications and standards for approximately 100,000 nursing service personnel, 64,000 of whom are VA employees, a professional nurse is needed to ensure effective policies that would accentuate the VA. Additionally, we believe heightened and informed awareness by the OPM regarding nurses would affect VA policies as well.

Lastly, ANA would like to take this opportunity to mention another policy of

concern to its collective bargaining members, which impacts health care personnel retention and recruitment within the VA medical system. Collective bargaining provides an effective mechanism for nurses to address practice and economic issues. Through the contract, nurses can have input into decisions that affect the clinical practice of nursing. Nurses have negotiated successfully for improved orientation for new graduates, professional practice committees which address nursing practice concerns, and input into patient classification systems which determine staffing levels. Experts agree that wage compression is a serious deterrent to attracting young, career-minded individuals to the profession. Contract negotiations are producing genuine advances in compensation, particularly for experienced nurses. These advances in practice and economics interact to make nursing an increasingly attractive career. Efforts to recruit new candidates and retain experienced nurses have been strengthened by the collective bargaining process in the private sector.

ANA and its constituent state nurses' associations have represented VA nurses since the early 1960s. In August 1983, ANA was granted National Consultation Rights at the agency level of the Veterans Administration. As a labor organization accorded these rights, ANA is entitled to reasonable notice of any proposed substantive changes in employment conditions and reasonable time to present its views and recommendations regarding these changes. The association, which holds similar rights with the Office of Personnel Management, will continue to exercise these rights in expressing nurses' concerns.

In July, the U.S. Court of Appeals for the District of Columbia Circuit ruled that the Veterans Administration administrators' authority to issue regulations concerning the working conditions of Department of Medicine and Surgery employees, including nurses supercedes the employees' rights to engage in

bargaining over those conditions. The administrator is not obligated, according to the court, to engage in collective bargaining on any condition of employment on which regulations have been issued. In the case, involving the Colorado Nurses' Association, the VA contended that it was exempt from the obligation to engage in collective bargaining with its nurses because the Department of Medicine and Surgery Statute grants the Administrator the sole authority to determine their conditions of employment "notwithstanding any law." The Colorado Nurses' Association and ANA argued that the Department of Medicine and Surgery's (DM&S) statute should be read in tandem with the Federal Service Labor-Management Relations' statute which provides that federal employees have the right to engage in collective bargaining with respect to conditions of employment. In accepting the VA's argument, the court stated, "The purpose of this language is clear: when the Administrator prescribes regulations concerning conditions of employment, he is to be unhampered by the range of federal personnel statutes and regulations that might otherwise constrain his authority."

The court's decision overturns an earlier ruling by the Federal Labor Relations Authority (FLRA). The FLRA had accepted the arguments of ANA and its state nurses' associations that Title 38, authorizing facility administrators to issue regulations, and Title 5 permitting collective bargaining, were not mutually exclusive At that time, the FLRA specifically held that a proposal to establish a grievance and arbitration procedure was within the duty to bargain. However, the appeals court concluded that, because Title 38 does not leave room for mandatory collective bargaining over union proposals relating to working conditions, the VA need not bargain over any of the proposals at issue in the case. The breadth of the current decision calls into question continued collective bargaining rights of VA nurses currently represented by state nurses' associations.

For several years, ANA and state nurses' association have vigorously fought to protect the rights of VA nurses to engage in collective bargaining. The Colorado case represents the consolidation of common issues from cases involving the New York State Nurses' Association and the Illinois Nurses' Association.

ANA believes that Congress intended for the VA nurses to have the same rights and protections under collective bargaining that private sector nurses enjoy. Granting collective bargaining to Title 38 employees was considered to be a recruitment and retention initiative. ANA therefore, adamantly believes the recent Court of Appeals' ruling will have an adverse impact on the VA's ability to attract health care professionals.

In closing, ANA and AORN reiterate its commitment to assuring quality nursing care to our nation's veterans. As a profession, nursing has always responded to health care crises, and we pledge to work with the VA to provide the nurses necessary to operate the VA health system. We hope that these hearings help maintain the ability of the VA to provide quality health care. Thank you again for the opportunity to present our concerns and recommendations.

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA HOSPITAL BED LEVELS AND THE SHORTAGES OF NURSES
AND OTHER HEALTH CARE PROFESSIONALS IN THE VA

WASHINGTON, D. C. SEPTEMBER 7, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States, I wish to thank you for affording us this opportunity to present our views concerning Veterans Administration's statistics, policies and administration of hospital bed levels, and the impact of the shortages of nurses and other health care professionals on the quality and quantity of health care delivered to veterans. The concerns which are to be addressed at today's hearing are especially urgent in light of the fact the VA's already over-taxed health-care system must soon answer the needs of our swiftly growing older veteran population. The VFW extends its appreciation to this Subcommittee for this demonstration of your sincere concern and commitment to ensure that this nation's veterans health care needs are provided for.

For a number of years now the VA has misled the veteran public with respect to the number of beds in VA medical centers (VAMCs) which are actually "operating," that is, available for the medical care of veterans. While the VA has managed to provide adequate health care over this period, the capacity of its medical centers to properly provide health care at current levels has been stretched practically to the breaking point.

The VA is mandated by law to maintain 90,000 operating beds in its medical system. These beds are needed to provide for the veteran population as well as to maintain a contingency capacity to assist the Department of Defense in time of war or national emergency. For reasons known only to certain VA bureaucrats and a number of budget slashers at OMB, the VA has maintained the fiction that they are in conformance with the law. The truth of the matter is, however, those beds are simply not there.

There has been reference within the VA for several years to the concept of "phantom beds." Phantom beds are those which are officially listed on paper as operating beds for the purpose of complying with the requirements contained under Title 38, USC, but which are actually not staffed and available for patient care. By far and away, and despite official denials, the primary reason for the large discrepancy between paper and actual operating beds, "phantom beds," is the lack of personnel to staff them. This has been borne out through the site visits of our VFW Field Representatives, as well as by other informational sources available to us.

As you know, a report from the recent site visits to 16 VA medical centers by a group of House Veterans' Affairs Committee staff members provides graphic evidence of the problem. Of the 14,939 beds authorized through the 16 visited VAMCs, 12,960 were officially counted as operating, that is available for veterans' health care. However, from out of this reduced total only 11,011 were actually available or operating. So just within those 16 VA hospitals, we have a total of 1,949 "phantom beds" of which 1,771 were identified by hospital management as closed due to insufficient staff. Of course, the problem of closed beds is not the same at all hospitals; three individual hospitals within the survey have no bed shutdown due to staff shortages. The report indicates the proportion of operating beds which are closed due to

inadequate staff at the individual hospitals range from 2.5 percent to 36.3 percent. But, taken as a whole, the problem is very serious indeed. In hospitals that do have staff shortages leading to closed beds, the average proportion of operating beds which are not adequately staffed "phantom beds" is 19.1 percent. As it now stands, there are considerably fewer operating beds within the VA system than are authorized, and of that reduced number a substantial percentage would seem to be "phantom beds" which exist only as a statistical fiction rather than as an actual health care resource.

At the very heart of this terrible situation is the lack of adequate funding. Utilizing information provided by the VA, the Congress has provided VA budgets in recent years designed to support slightly in excess of 194,000 full-time employees. In order to adequately provide for VA personnel costs, the Congress, and the VFW places special emphasis on the tremendous effort and leadership exercised by this Subcommittee in this regard, has in fact consistently exceeded the personnel funding requested by the Administration. However, it is only now becoming apparent to what extent funds for VA medical care have gone increasingly to pay personnel costs in order to make it possible for the VA to attract and retain skilled medical staff in competition with the private sector.

Special salary rates have gone a long way toward enabling VA medical centers to attract and retain scarce medical personnel in the highly competitive employment market. However, since the individual medical centers must absorb the costs of these special pay rates, reductions in certain other areas have been made to pay for them. Out of the 16 hospitals included in the House survey, 12 report that funding sources are inadequate for the special salary rates that have been put in place. Thus, there is a dilemma wherein the solution designed to resolve staffing problems has itself created other staffing problems by consuming a large share of the available personnel and health care dollars.

In the report it is stated, "Funds to meet the new payroll costs have largely come from replacement equipment and maintenance and repair accounts, leaving these latter needs unmet. The decision of hospital directors to transfer funds from other operating accounts to fund personnel costs have made it possible for the VA medical care system to continue functioning. However, having exhausted such accounts, the hospitals now have no recourse but to reduce capacity. In the near term, inadequate funds for equipment and maintenance are likely to further reduce both capacity and efficiency and to threaten the quality of care." It is the VFW's position that beds without personnel and other resources necessary to provide care should not be tallied among actual operating beds.

One now familiar OMB ploy to justify reducing the VA's health care capability is to cite the relatively low average daily inpatient census, roughly 55,000, for the VA nationwide. However, with beds officially "operating" on paper but actually unusable, it is no surprise that VA occupancy rates appear to be low. The demand for health care from the VA by veterans is rising and will continue to rise, and it is the VFW's contention that if there were more VA health-care beds actually available and operating the patient census would be considerably higher. By reducing the VA's actual ability to provide health care and thereby artificially reducing its work load, OMB has fabricated the justification to further reduce VA health care capability.

At this point in time, the majority of all VA medical centers are facing a critical shortage in operating funds. Exacerbating this already critical situation is the impact of the diversion of operating funds of the individual medical centers to other DM&S departments and areas over the last few years. This has ensued directly out of OMB having mandated an arbitrary and burdensome one percent "productivity improvement" levy and requiring VA absorption of a substantial portion of the annual COLA pay raise for employees. As a result of this, VA hospitals are faced with a situation where they have no further resources on which to draw and will soon be unable to recruit and retain the health-care personnel needed to prevent further bed closures and reductions in the ability of the VA to deliver medical care.

It is now frighteningly evident to us that the VA's "phantom beds" are not only reducing its current health care capability, but are also contributing

to the further erosion of the VA health-care system by creating the harmful and deceptive appearance of a low patient census. The VFW is adamant that only hospital beds which are properly staffed and funded should be counted as operating beds, we also urge that the VA be provided with additional funding with which to meet their personnel demands. If this does not happen, it is our assessment that before this fiscal year is out the amount and quality of health care provided to this nation's veterans will severely degenerate.

The VFW has learned that nurses critically needed by the Veterans Administration are not there. Registered nurses, licensed practical nurses and nursing assistants are absolutely crucial to the quality health care system we demand of the Veterans Administration. They are the professional foundation upon which the whole medical structure depends for nurturing of the ill and infirm.

Although there are men sharing this noble profession of nursing as well, the primary care givers in our Veterans Administration Medical Centers are women. They stand alert to the slightest falter in a patient's vital signs in the many Intensive Care Units. It is their caring touch and confident smile to which thousands of veteran patients respond each day on the various wards. As recipients, we cannot be more grateful for the tremendous strides and the sophisticated technological explosion which has served medicine so well in the latter half of the twentieth century. Nevertheless, it is fair to state that our impressions of care received, and the will to hang in there and fight back toward the road to recovery, are still formed and nurtured by the "hands on" ministrations of the nursing staff. They are the health professionals most "real" to us and veteran patients. Unhappily, there is evidence that their ranks are thinning nationwide.

The expanding workplace and new horizons for women may be a principle underlying cause for the now current reduction in enrollment in nursing schools. As the general health of our population improves, and as the percentage of older citizens increases, when the need for hospitalization strikes today's patients, they tend to be sicker. Therefore, intensive care beds appear to have been expanding geometrically. This high stress environment calls for specialty nurses who are increasingly subject to an effect which they aptly call "burnout." Thus, the curious paradox that three desirable elements, that is, a longer life span for the population in general, expansion of opportunity for women and increasingly sophisticated medical techniques, combine to conspire against the care giver whom we cannot do without.

Which brings us to the area of our first concern, the nurse professional caring for our veterans in the nationwide VA health care delivery system. The Veterans Administration has to compete for the needed nursing staffers to provide quality care to our veterans. As is patently obvious, when the pie shrinks, somebody has to be on the losing end. We have got to ensure that it is not the VA, whose mission it is to provide for our veterans.

Since, as noted earlier, this situation has struck before, a long-term solution was clearly required. The VFW was under the misapprehension that the mechanisms for a long-term solution were in place. That mistaken assumption was based upon the enactment of Public Law 96-330 in August 1980. In recognition of a nationwide nursing shortage which was reaching crisis proportions in the late 1970s, Congress mandated a pilot program and study to "Evaluate the effectiveness of taking various administrative actions on the VA's recruitment and retention efforts related to nursing personnel, including registered nurses, licensed practical or vocational nurses, and nursing assistants." In its deliberations leading up to the passage of that law, the sense of the Congress was expressed as follows: "It is the Committee's expectation that by undertaking the mandated pilot program and study, the VA should generate significant data on which actions have a cost-effective impact on the agency's recruitment and retention efforts directed at nursing personnel and that this information should be helpful in markedly improving the agency's success in recruiting and retaining such personnel."

The required study and pilot program were duly carried out. A number of recommendations followed. In addition to pay inequities and other problem areas identified, we have narrowed those recommendations to three core areas which impact most on nurse morale and effectiveness. Simply stated, those

three are: not enough nurses to do the job; lack of tuition reimbursement to upgrade skills; and inadequate support services to permit the nursing professional to concentrate her attention on the patient.

The latter issue needs a little expansion. The thrust here is that if the nurse is to focus her attention upon you, the patient, an adequate number of people and machinery need to be in place as ancillary support. This includes, but is not limited to, pharmacists, housekeepers, ward secretaries, social workers and computer enhancement for physician's orders and other clinical data.

At present, Special Salary Rate Request Review Process has been imbued with a sense of urgency and we are assured that action is being taken in those areas where the VA is losing nurses and futilely running employment ads without takers. For the long-term a Survey of Health Occupations Staff was fielded in early December 1982 to "collect data to assess recruitment and retention trends among several VA health occupation." That is intended, we are told, to form the basis for the long range plan to frustrate cyclical shortages. We are afraid that the VA is already too far behind the power curve.

The VA has shown innovation in the past, for example, by recruiting nurses from Puerto Rico where there was an overage and bringing them to facilities in California. We hope that similar ideas are being explored now. The bottom line, the VA must be provided with sufficient funding with which to maintain an adequate pay schedule as well as other inducements for nurses and other health care professionals to remain competitive with the private sector.

Thank you Mr. Chairman, this concludes my statement and I will be happy to respond to any questions you may have.

ADDENDUM TO THE

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA HOSPITAL BED LEVELS AND THE SHORTAGES OF NURSES
AND OTHER HEALTH CARE PROFESSIONALS IN THE VA

WASHINGTON, D. C. SEPTEMBER 7, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

This addendum to the VFW testimony of September 7, 1988, is comprised of excerpts of VFW Reports of Survey conducted at various Veterans Administration Medical Centers throughout the nation by VFW Field Representatives. These excerpts will illustrate the severe problems now facing the VA's Department of Medicine and Surgery in providing for the health care needs of this nation's veterans because of inadequate funding. It is not the intension here to illustrate all the strenghts and/or weaknesses of the VA health care system, rather only to show in a clear and graphic manner that the integrity of the VA health care system is now threatened by budgetary shortfalls. Tragically, certain ill and disabled veterans are even now being deprived of the high quality and compassionate care which is their due.

VFW Report of Survey of the Prescott, Arizona, VAMC
July 25-28, 1988

The medical center is authorized 217 beds in the hospital plus a 214-bed Domociliary for a total bed capacity of 431...only 350 beds are open.

* * *

The operating budget for FY 88 is $21,556,700 which is about $140,000 above last fiscal year. This did not, however, keep pace with inflation. Expectations for FY 89 is for a decrease in funding.

* * *

The hospital has been grouped with Phoenix and Tucson for shared services. The Prescott Medical Center has a need for 50 CT scans per month. However, Phoenix can only provide 8 or less per month. This leaves the patients at Prescott without the services of this important diagnostic procedure since the center does not have the funds to contract for this service.

* * *

A meeting was held with all the Medical Service physicians to receive their views on the change of mission of the medical center. It was the general consensus that the practice of medicine at this medical center had been set back fifty years without the availability of surgery. The non-availability of surgical consultants to become involved early in the case, causes many concerns with the physicians.

Many of the medical test and procedures cannot be conducted without surgical back-up such as biopsy and endoscopies...

The lack of surgical back-up also has a serious impact on the intensive care unit as well as the respiratory technicians

and nurses. Decisions by the health care provider can be adversly affected when they know that if any thing goes wrong, there is no Surgical Service back-up.

A hearing was held on July 5, 1988, by Senator Dennis DeConcini for the Senate Veterans' Affairs Committee, on the closing of the Surgical Service at this medical center. According to information received, testimony was given that this service had only performed 35 to 55 surgical procedures a year for the last 6 years...the annual reports from the Surgical Service for the last 10 years reveals that the number of operations far exceed the number given at the hearing for every year.

The following chart shows the number of procedures done during the last ten years:

FY YEAR	MAJOR	MINOR	DIAGNOSTIC PROCEDURES	TOTAL
1978	527	421	555	1,503
1979	474	468	544	1,486
1980	478	473	521	1,472
1981	439	409	477	1,325
1982	366	418	233	1,017
1983	364	365	250	979
1984	444	314	407	1,165
1985	340	329	454	1,123
1986	227	306	713	1,246
1987	10	607	424	1,041

* * *

This service [radiology] has a total of five rooms. There are four radiography rooms and one ultrasound room. Of these, three of the radiography rooms need to be replaced with new equipment. The head unit is over 25 years old. The tomographic unit is now due for replacement as it has reached its life expectancy and the radiographic/flurorscopy room reached this point over three years ago...

VFW Report of Survey of the Manchester, New Hampshire VAMC
July 19-22, 1988

The director has been on board for approximately five years. His major concern was the budget. The medical center is expected to have a million dollar plus shortfall in fiscal year 1989. With the high turnover rate in nursing service, overtime has cost the facility $6,000 per pay period. At the height of the overtime period, the medical center was expending $15,000 per pay period.

The Office of Management and Budget (OMB) initative presented to the Congress (1 percent productivity) has cost the medical center $245,000 which equates to seven Full Time Employee Equivalent (FTEE). In the last three years, this facility has lost 35 FTEEs.

* * *

Statistics by OMB indicates that the medical center should be able to do with $30,000 less because of the Decentralized Hospital Computer Program and the budget was so reduced.

The budget reductions experienced this fiscal year and scheduled reductions next fiscal year have and will continue without doubt seriously affecting the quality of care this VAMC can provide.

VFW Report of Survey of the Fort Howard, Maryland, VAMC
June 13-17, 1988

During our survey, we identified numerous deficiencies which required specific corrective action. Several deficiencies noted in our 1984 survey report have not been corrected. The physical plant is in drastic need of extensive renovations, especially the patient care areas. The rooms were very cramped and were not equipped with oxygen, air or suction. Patient privacy requirements were severely compromised throughout the facility, especially in the several 16-bed commune type rooms. The Nursing Home Care Unit is very crowded and the nursing stations are poorly located and not designed for patient observation. There are 11 unsafe quonset huts, which house several key clinical support functions, that are deteriorating rapidly. Several distinct fire and safety deficiencies were recognized which included insufficient sprinkler heads to respond to the problems associated with deadend corridors.

Management is totally aware of the serious problems that exist at this medical center. However, a higher level of support and funding is required to resolved this situation. We recommend Central Office authorize the funds to immediately activate construction projects which will modernize this facility as soon as possible. The need to correct the longstanding functional and space deficiencies that have been neglected at this facility over the past years is essential...

* * *

The current staffing ceiling of this [nursing] service is 163. However, there is a serious shortage of nursing staff. At this time of our survey, there were 27 RN vacancies within an authorized ceiling of 85 registered nurses. In addition, there were 23 LPN vacancies within a ceiling of 40 licensed practical nurses...

* * *

We asked if the VA medical center was still considered the preferred employer within the community and the response was NO. It was opined nursing salaries are very insufficient in this highly competitive market and special pay incentives are required to retain intermediate and senior pay grade nurses as well as initial and associate grade levels.

* * *

We noticed several radiology items listed on the District's unfunded equipment list. We were informed several pieces of equipment were beyond their replacement dates and were producing poor diagnostic images. The Ultrasound equipment was inoperative because replacement parts could not be obtained. The nuclear medicine equipment was outdated and constantly down for repairs. We recommend Central Office provide the funds required to modernize this clinical support service before it has further impact on patient care.

VFW Report of Survey of the Fort Lyon, Colorado, VAMC
May 16-20, 1988

This medical center has an average occupancy rate in the mid-90 percent range. This, when combined with the budget inadequacies and staff vacancies, is causing major challenges to the management skills of the hospital's leadership. Currently, the medical center is 25 to 30 short of the required staffing to adequately care for the veterans. A policy of limiting care to the nonservice-connected veterans has had to be placed in effect. To enable the hospital to maintain the number of employees they now have and still fund their mandated share of

employee pay raises, it was necessary to divert monies from non-reoccuring and equipment funds to the salary account. This is creating problems in keeping the hospital running efficiently.

* * *

While the station equipment is in good condition, the loss of non-reoccurring funds may affect the continuation of this fact. The station has a new contract for the removal of their asbestos which was not correctly completed by the previous contractor. The station fire alarm system is piecemealed among the various buildings. A new system should be installed.

* * *

The current freeze on hiring support personnel is seriously affecting the ability of the health-care professionals to accomplish their mission. Many hours of hands on care by professional health care personnel are lost due to them having to accomplish the task of support personnel. This is the penny wise, pound-foolish situation found throughout the medical centers in the VA.

VFW Report of Survey of the Albuquerque, New Mexico, VAMC
April 18-22, 1988

This service [nursing] has an FTEE of 439.9. They are authorized 283.9 RNs with only 249.3 on board. Total vacancies number 53.6 with 19 being LPNs or nursing assistants. The turnover rate is running in the high 20 percent to low 30 percent range. There reasons given for leaving are for better working conditions, every other weekend off and better salaries.

* * *

This is one of the hardest hit [surgical] services by the current equipment budget shortages. They have 18 items on the station's equipment needs list which included drills and GU instruments. The service has 5 full-time surgeons and 19 residents. Last fiscal year, the service performed 2,098 major and 803 minor procedures, including 142 open heart surgeries. This fiscal year to date, they had completed 150 open heart surgeries.

* * *

...due to the medical center budget problems, prosthetics has been requested to requce expenditures 10 percent for the remainder of the year. Since the budget for FY-88 was only $840,000, this would leave only $310,385 for the last 2 quarters. To meet this goal, supplies will have to be allowed to diminish and orders for prosthetic devices will have to be delayed. To assure that disabled veterans do not face the prospect of being unable to receive needed supplies and devices, supplemental funding will be required.

VFW Report of Survey of the Boston, Massachusetts, VAMC
March 21-25, 1988

...In reaction to the RAM, not unlike other facilities, this medical center initiated appropriate measures to "cut the fat". Compounded by stretching available staff as far as possible, this has resulted in an inability to adequately provide care to patients. While marginally staffed wards can manage the patients under normal conditions, the situation can be intolerable when the mix of patients includes many seriously ill.

* * *

This service [nursing] has a Full-Time Employee Equivalent (FTEE) of 311 Registered Nurses (RN), 88 Licensed Practical Nurses (LPN) and 125 Nursing Assistants (NA). There are 71.5 RN and 48.5LPN vacancies. As mentioned earlier in this report, there are 169 beds vacant that can be directly linked to the critical staff nursing shortages.

* * *

The last Admission Time Study was conducted during the week of February 1, 1988...Three hundred ninety-eight applicants were surveyed with an average admissions time of 3 hours and 17 minutes. This time definitely does not show admissions in a favorable light. The unavailability of admission beds and the desperate overcrowding conditions experienced in the ambulatory care area and throughtout the hospital contributes to the long admission times.

The occupancy rate dropped from 72 percent in FY 86 to 67 percent in FY 87. Wards closed due to nursing shortages do not decrease operating bed levels. These may only be adjusted with Centeral Office approval. Although the active wards had a generally high occupancy rate, those wards placed temporarily out of service helped cause the overall level to drop in comparison to FY 86. I find it difficult to understand that a medical center with an average occupancy rate of 58.3 percent is experiencing grave difficulties in admitting patients. Centeral Office should consider changing the way operating beds are accounted for.

* * *

The nursing shortage at this medical center must be considered as crucial. Numerous beds have been closed, resulting in critical problems for veterans requiring admission. Patients were observed on litters in the corridors of ambulatory care, waiting for beds to become available for admission. Non-urgent admissions are cancelled frequently to accommodate emergencies. The mechanism used by VACO to address nursing salary differentials, i.e., special rates, appears to be inherently designed to lag behind the community hospitals. Authority should be delegated to the Medical Center Director to address salary inequities for not only nurses, but also for other personnel shortages which are affecting the delivery of quality care.

It was reported that this medical center possibly has five-million dollars of unmet equipment needs. Many items have passed their life expectancy without being replaced. Fears are mounting regarding the inevitable day when diagnostic procedures cannot be performed, even if technicians are available. We request that Region become involved and responsive to these unmet needs.

90-284 0 - 88 - 8

ORAL REMARKS OF SEPTEMBER 7, 1988, BY

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA HOSPITAL BED LEVELS AND THE SHORTAGES OF NURSES
AND OTHER HEALTH CARE PROFESSIONALS IN THE VA

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the entire membership of the Veterans of Foreign Wars I wish to thank you for affording us this opportunity to present our views concerning the severe problems now facing the VA's Department of Medicine and Surgery due to inadequate funding and the shortages of nurses and other health care professionals.

Mr. Chairman, I have already submitted for the record the VFW's statement addressing this issue, which presents our views in general, as well as an addendum which presents particular instances of diminished and/or substandard health care being provided at certain VAMCs. Rather than reading from these two documents at this time, I will now cite additional concrete examples of the inadequate funding and management of DM&S. This material was obtained by telephonic inquiries made to a sampling of our Department Service Officers around the country. Additionally, our Field Representatives have provided us with information concerning additional problems they have encountered in their more recent surveys of VA facilities. We will also present a list of names of veterans who have recently been denied health care by the VA.

DEPARTMENT OF MEDICINE AND SURGERY

Loma Linda, California VAMC
- Two wards closed due to nursing shortages.
- Six to eight hour ambulatory care waiting time.
- General Turnage dedicated a 60-bed addition to the Nursing Home Care Unit at this facility in summer of 1987. In February 1988, our Field Representative noted that the 120-bed combined facility then housed only 69 patients due to staffing shortages.

New Orleans, Louisiana VAMC
- Ran out of money in each quarter of this Fiscal Year.

Oklahoma City, Oklahoma VAMC
- Inadequate funding for prosthetic service.
- The Chief of Staff characterized the operating suites as dangerous and obsolete.

Fort Howard, Maryland VAMC
- ICU closed due to nurse shortage.
- 37 of 85 registered nurses authorized were short.

Boise, Idaho VAMC
- Prosthetic service tapped out in funds before end of each quarter.

Albuquerque, New Mexico VAMC
- Ward closed due to nursing shortages.

Wilmington, Delaware VAMC
- Ward closed.
- Long delays in outpatient scheduling.

San Antonio, Texas VAMC
- Less than 90 beds of 120 bed Nursing Home Care Unit filled because of lack of nurses.
- No replacement equipment money available to this facility.

White River Junction, Vermont VAMC
- Cut beds 20 percent due to nursing shortages.

Boston, Massachusetts VAMC
- 169 beds vacant due to nursing shortage.
- Five million dollars in unmet equipment needs for items that have passed their life expactancy.

Cleveland, Ohio VAMC
- Radiology service on contract since it cannot be provided by the medical center in a timely manner.

West Haven, Connecticut VAMC
- Monitoring equipment in Surgical Intensive Care Unit considered unsafe.
- Chief of Surgery would not personally undergo surgery there.

Fayetteville, North Carolina VAMC
- Nursing shortage of 25 percent.

Kanasas City, Missouri VAMC
- Prostetics funding shortages.

Muskogee, Oklahoma VAMC
- Cannot afford to treat NSC outpatients.

Washington, D.C. VAMC
- Closed wards and beds due to budgetary and staff problems.

Seattle, Washington VAMC
- Staff shortages have led to the recent discontinuance of outpatient treatment for nonservice connected veterans.

Denver, Colorado VAMC
- Closed wards due to shortage in funds.
- Prosthetics service 30 to 40 thousand dollars short, supplemental funds have been requested.

San Francisco, California VAMC
- A funding deficit so great that highly unusual intra-regional borrowing efforts are underway to rescue the facility.

Indianapolis, Indiana VAMC
- Closed a medical ward due to construction. After construction completed, Social Work Service occupied the space.
- Significant delays in shceduling clinic appointments.

Reno, Nevada VAMC
- Two wards closed due to budget cuts.
- Prosthetics restricting issuance due to budget cuts.

Togus, Maine VAMC
- A General Medical Ward of 38 beds closed six months ago due to nursing shortage.
- An Intermedicate Ward of 21 beds closed to allow nurses to go on vacation during the summer months.

EXTRACTS FROM VFW FIELD REPRESENTATIVES SURVEY REPORTS

Survey of VAMC West Haven, Connecticut
November 30 to December 4, 1987
- "There are 107 beds closed due to staffing shortages..."

Survey of VAMC Lebanon, Pennsylvania
January 11-15, 1988

- "There is an immediate need to update the patient's monitoring system in intensive care unit..."
- "We recommend new state-of-the-art equipment be installed in this unit as soon as possible."

Survey of VAMC Oklahoma City, Oklahoma
February 8-12, 1988

- "As the tertiary care facility for the state of Oklahoma, and the surrounding states in some medical specialties, the budget does not adequately support the medical center's mission." RE: Surgery
- "It is impossible to understand how the Joint Commission on Accreditation of Hospitals continues to reaccredit this medical center or that medical schools have allowed their students to be trained in this antiquated and potentially hazardous environment. All patients, both preoperative, use the same doorway and corridor in which soiled and contaminated waste is removed. The operating suites are severely undersized which requires surgeons and support staff to compete for space with required medical equipment. The suites have insufficient electrical outlets for modern medical equipment requiring a jumble of electrical extension cords. This in itself creates a danger when surgerical team members must devote part of their concentration on where to step or move. Waste water from overflowing toilets, from the surgeons' locker rooms located over the operating suites, occassionally leak into the space. It is estimated that the operating rooms are from 25 to 50 percent deficient in space requirements."

Survey of VAMC Sioux Fall, South Dakota
March 2-5, 1988

- "...the station's operating budget is considered very lean. In fact, they were given $266,146 less than what was spent last Fiscal Year."

Survey of VAMC New Orleans, Louisiana
March 14-18, 1988

- "Central Office must improve the budget process so that large downward adjustments are not required five months into the year retroactive to the first of the Fiscal Year. Funding for medical, surgical and prosthetic supplies should be improved so that they do not run out halfway through the quarter."

Survey of VAMC Northport, New York
January 4-8, 1988

- "The medical center's radiation therapy program is temporarily closed as a result of staffing shortages. This presents major transportation problems for patients who must travel to Brooklyn VAMC for treatment."

Survey of VAMC Kansas City, Missouri
December 14-18, 1987

- "Central Office must monitor this facility's new and replacement equipment needs very closely and give serious consideration to special funding to rectify this problem before it has further impact on the care that is provided to our nation's veterans."

Survey of VAMC Cleveland, Ohio
November 16-20, 1987

- "There is a need to update the monitoring system in the coronary units. They are antiquated and are difficult to read."

Survey of VAMC Topeka, Kansas
November 16-20, 1987

- "On top of employee shortages, there is a morale and burnout problem, which has been created by the increasing work load, constant staff cutbacks and freezes."

I will now conclude with a list of names provided to us by our Service Officers of veterans who have been denied hospitalization by the VA within the last few months.

NAME	I.D. NO.	CONDITION
Milton Collins	SSN 498-18-9841	Reported that he is NSC for heart condition and was denied hospitalization at Kansas City.
D. W. Harmon	SSN 519-24-4026	Reported that he was referred to a civilian hospital by VAMC Reno OPC rather than admitting him.
Ted Furuga	N/A	Reported that he was denied hospitalization at West Los Angeles. No other details available.
Raymond Ramirez	C 25-952-455	Unable to get bilateral lower prosthesis replaced at VAMC Wichita, Since May 9, 1988.
William A. Esser	C 03-854-790	Has been waiting for over a year for lower prosthesis from Wichita VAMC.

Additional names may be available early next week after a number of our Service Officers return from vacation.

Mr. Chairman, this concludes my statement. Once again, I wish to thank you and commend you for conducting this hearing today. It is the VFW's fervent hope that by working together we may prevent the already very bad situation facing the VA's Department of Medicine and Surgery from turning into an outright system wide tragedy. I thank you.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

November 21, 1988

The Honorable G. V. "Sonny" Montgomery
Chairman
Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Therehere follows a list of names provided to us by our Service Officers of veterans who have been denied hospitalization by the VA. This list was compiled in preparation for the September 7th hearing before the Subcommittee on Hospitals and Health Care, Committee on Veterans' Affairs, U.S. House:

NAME	I.D. NO.	CONDITION
Milton Collins	SSN 498-18-9841	Reported that he is NSC for heart condition and was denied hospitalization at Kansas City.
D. W. Harmon	SSN 519-24-4026	Reported that he was referred to a civilian hospital by VAMC Reno OPC rather than admitting him.
Ted Furuga	N/A	Reported that he was denied hospitalization at West Los Angeles. No other detsils available.
Raymond Ramirez	C 25-952-455	Unable to get bilateral lower prosthesis replaced at VAMC Wichita, Since May 9, 1988.
William A. Esser	C 03-854-790	Has been waiting for over a year for lower prosthesis from Wichita VAMC.

With best wishes and kind regards, I am

Sincerely,

James N. Magill

JAMES N. MAGILL, Director
National Legislative Service

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202-543-2239

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
September 7, 1988

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans and its Ladies' Auxiliary, I want you to know how very much we appreciate the opportunity to present our views regarding the current state of the Veterans Administration's Department of Medicine and Surgery (DM&S).

Mr. Chairman, the subject of today's hearing -- which we simply define as critical underfunding of the VA's health care system -- is most timely.

With ever-increasing and alarming frequency, we are being contacted by veterans and our corps of National Service Officers (NSOs) describing restrictions in the type of care provided, denial of care and implementation of policies that can only be described as radical departures from the traditional VA health care delivery system.

Mr. Chairman, the DAV has recently completed two separate surveys of our National Service Officers representing our efforts to gain a sense of what is actually occurring in VA medical facilities across the country. The results of these surveys will be discussed later in my testimony.

Mr. Chairman, the DAV applauds you and the full Committee for your recognition of the funding problems plaguing DM&S and the aggressive actions taken to more clearly define its magnitude. I am, of course, referring to the recently completed site visits and subsequent survey of VA medical facilities conducted by the Committee.

Those of us -- and I believe there are many -- who do not see the system through rose-colored glasses or with tunnel-vision, are truly appreciative of the Committee's and staff's efforts to piece together a truly complex puzzle in a meaningful and understandable fashion.

As you are aware, Mr. Chairman, two years' ago, four veterans' service organizations -- AMVETS, DAV, Paralyzed Veterans of America and the Veterans of Foreign Wars -- joined forces to produce an Independent Budget for Veterans. Clearly, this exercise was born of our knowledge that funding of the Veterans Administration -- particularly DM&S -- was inadequate and, significantly more alarming, continuing on a downward spiral of erosion.

In our view, the funding deficiencies of DM&S are critical and progressively becoming more tenuous as concerns the future role the VA will play in the national health care delivery system.

Nearly six months' ago, a national conference call between VA Central Office and medical center directors revealed what could be interpreted as a poignant portrayal of the system.

At that time, VA medical center directors representing facilities as large and complex as Hines, Illinois, to rural hospitals like Miles City, Montana, and the Las Vegas, Nevada, Outpatient Clinic, painted clear, albeit dismal, common situations such as: management with no flexibility; drastically reduced and eroded funding levels; depleted equipment, maintenance and repair funds; employment freezes; workload reductions; operating deficits in the millions of dollars; concerns about quality patient care from a funding standpoint; inadequacy of the funding model (RAM); cancelling of facility projects; closures of entire wards; inability to implement new program initiatives; reductions of employees; changes in facility missions; concerns with medical school affiliations; and physician shortages.

Mr. Chairman, the continued erosion and decreasing real dollar budget available to individual VA medical centers and the resulting negative impact of the agency's mission is also a concern of many of the affiliated medical colleges working in partnership with the VA. We have learned of these concerns directly from deans of the various medical schools.

(As you are probably aware, Mr. Chairman, the Muskogee, Oklahoma, VA Medical Center affiliation with the Tulsa Medical College has effectively ceased.)

Two additional items we wish to briefly discuss are the draft versions of "Veterans Administration Department of Medicine and Surgery Fiscal Year 1989 Budget Problem Definition -- Options," dated July 6, 1988, and the "Chief Medical Director's Task Force Report on Fiscal Year 1989 Budget," dated July 28, 1988.

The first paper defines the budget problem as a projected Fiscal Year 1989 shortfall of $820 million based on known and potential budgetary requirements that exceed the current level of appropriations.

The second paper identifies a total of 86 options and recommends implementation of 17 specific options that have the potential to offset the projected Fiscal Year 1989 budget shortfalls.

Of all options presented, several deserve mention:

* Close medical centers
* Close Vet Centers
* Stop activation of newly constructed facilities
* Employee furloughs
* Do not implement Congressionally passed initiatives and program enhancements
* Drop prescription drugs for all outpatient care
* Restrict prosthetic services
* Eliminate the Chaplain Service

Mr. Chairman, what is abundantly clear from these documents is a large budgetary shortfall occurring in Fiscal Year 1989 and the agency's plans to counter this shortfall by dramatically eliminating, curtailing and denying VA health care services to eligible veterans.

It is interesting to note that nowhere in these papers -- or anywhere else -- has the VA set forth what appears to be a logical course of action, that being: an open, frank discussion to interested and competent authorities detailing the situation in meaningful terms with the goal being of maintaining the VA as a viable health care delivery service.

Mr. Chairman, the DAV has always held a keen interest regarding the VA's Prosthetic and Sensory Aids Service (P&SAS). Countless numbers of combat disabled service-connected veterans rely of P&SAS for devices and services that enable them to function on a day-to-day basis.

During Fiscal Year 1987 a VA-conducted survey found over 50% of all VA medical facilities reported delays in furnishing prosthetic services due to inadequate funding. Our best current information tends to indicate the situation has exacerbated in Fiscal Year 1988 and will continue to do so in Fiscal Year 1989.

Mr. Chairman, the $108 million funding level proposed for P&SAS in Fiscal Year 1989 will again prove to be insufficient in terms of an appropriate level of funding and the manner in which funds are allocated to field stations.

DM&S, as well as the Administrator, is aware of the situation, yet nothing occurs to remedy the problems. The VA's response to our concerns is to establish task force after task force with no substantial solution forthcoming.

Increased funding, to a level of approximately $120 million is part of the answer. An equal part rests with an allocation methodology of prosthetic dollars to the field that insures, to the greatest extent feasible, those dollars will be used to provide prosthetic services and not, as has apparently occurred in the past, be diverted for other purposes.

When reviewing and discussing the overall funding dilemma facing DM&S, we are hopeful the Subcommittee will carefully scrutinize the entire funding process involving one of the most visible and certainly sustaining services within the DM&S: Prosthetics and Sensory Aids.

Mr. Chairman, with the realization that inadequate funding exists, the DAV recently surveyed our National Service Offices attempting to learn the true magnitude of the situation.

NSOs were requested to provide documented evidence of situations occurring at VA health care facilities within their jurisdictions that, as a result of budget inadequacies, were producing restrictions, curtailments or other disruptions in the overall delivery of health care services to eligible disabled veterans.

We received responses from each of our 66 NSO offices located in every state, including the District of Columbia and Puerto Rico. Those responses were reviewed, analyzed and "Fact Sheets" were prepared detailing the situation specific to each facility on a state basis.

Mr. Chairman, we have provided each member of Congress with an appropriate "Fact Sheet" specific to the VA medical facility(ies) located within their state.

It is clearly evident that each facility is undergoing specific challenges and changes while attempting to continue to operate despite an inadequate budget. Obviously, some facilities are in worse shape than others, but all are realizing significant difficulties.

System-wide many common problems are readily apparent: bed closures; closures of entire wards; curtailing services and programs designed to treat eligible veterans; reducing or eliminating surgical procedures, especially elective surgeries; lack of funds to purchase, maintain or repair medical equipment; absurd waiting times for veterans to be seen for clinical appointments; forcing veterans to wait intolerable periods of

time to be furnished prosthetic devices and supplies, or outright denial of these items; restricting and denying nursing home care; restricting the types and quantities of medications provided; excessive delays in filling prescriptions; deferring or eliminating construction projects; shortage of medical personnel, especially nurses; curtailment of outpatient services; inadequate safety standards; referral of veterans to other facilities, including private sources; closure of clinics to new patients; closures of satellite clinics; vacant positions not being filled; inadequate funds for drugs and medical supplies; and inadequate travel funds.

The list could go on and on.

The second endeavor undertaken by the DAV was a follow-up survey of our NSOs requesting specific information concerning individual veterans they may be aware of who have been denied appropriate VA medical care.

Mr. Chairman, to date we have received a number of responses to our request and we have provided the Subcommittee a list of individual veteran's names and circumstances relating to the various types and degrees of denial of medical care.

Mr. Chairman, the DAV finds it almost incredulous that the VA health care system is in the current fiscal dilemma. However, we find it totally unconscionable -- based on the wealth of documented evidence -- that top-level management has continually maintained that there is no funding problem. Certainly, the surveys conducted by your Subcommittee dispute the "we're O.K." rhetoric we are constantly barraged with. Clearly, our own information tears away at the flimsy fabric the agency is fond of draping over the system, attempting to disguise reality.

Mr. Chairman, if the VA is to remain a viable health care delivery service then two initial and crucial steps must be taken.

First, the agency must present the current state of the Department of Medicine and Surgery in a candid fashion regarding their present fiscal condition.

Secondly, Congress must be made aware of the current situation and come to a public policy decision regarding the future of the VA health care system. If the decision is the VA should remain and function as a vital ingredient to the national health care delivery system, then it is imperative that adequate funding be provided to enable the agency to carry out its mandated mission.

One final thought in closing, Mr. Chairman. The DAV wishes to extend our appreciation to the dedicated employees of the Veterans Administration who, faced with adversity over the years, have continued to create and implement creative management strategies in the field that have thus far tended to compensate for what has been at least a decade of decrimental funding. Unfortunately, the reality of today is that there remains no more creativeness that will allow individual medical facilities to continue to provide an array of quality health care services. The resources have been stretched to, and sometimes beyond, acceptable limits. The only remaining option, absent an infusion of dollars, is wide-spread and sweeping vertical cuts in VA health care services. This is a situation none of us wish to witness.

Again, Mr. Chairman, the DAV wishes to applaud you and the Subcommittee for your keen interest and staunch advocacy on behalf of this nation's disabled veterans.

This concludes my testimony and I would be pleased to respond to any questions you may have.

BLINDED VETERANS ASSOCIATION
477 H STREET, NORTHWEST • WASHINGTON D.C. 20001 • (202) 371-8880

BLINDED VETERANS ASSOCIATION

TESTIMONY BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTHCARE

U.S. HOUSE COMMITTEE ON VETERANS AFFAIRS

SEPTEMBER 7, 1988

PRESENTED BY THOMAS H. MILLER
DIRECTOR OF GOVERNMENTAL & COMMUNITY RELATIONS

CHARTERED BY THE CONGRESS OF THE UNITED STATES

Mr. Chairman and members of the Subcommittee, The Blinded Veterans Association (BVA) appreciates this opportunity to present our views on the Veterans Administration's statistics, policies and administration of hospital bed leves and the impact of shortages of health care professionals on the quality and quantity of health care delivered. Blinded veterans, like nearly all others in the veteran community are becoming increasingly concerned and skeptical regarding the VA's ability to meet the increasing demand for health care in the current environment of rapidly diminishing resources. Although we are told that the VA is in great shape and has more money than ever before, one only has to visit a VA Medical Center or Outpatient Clinic to learn that services are being drastically curtailed, due to shortages of professional staff, reductions in FTEE, or freezes on positions that have become vacant. Beds are being closed and even entire wards are shut down because Medical Centers do not have sufficient staff to operate them.

1. Mr. Chairman, BVA is deeply concerned that all veterans in need of hospital care receive quality care in a timely fashion. Obviously, we are especially concerned about the availability of rehabilitation beds for our nation's blinded veterans. It is this issue we would like to address today.

The Veterans Administration (VA) operates eight Blind Rehabilitation Training Programs within the 172 Medical Centers. Five of these programs are referred to as Blind Rehabilitation Centers and three are known as Blind Rehabilitation Clinics. Each program offers comprehensive, residential blind rehab training designed for distinct populations of blinded vets. The Center Program is designed for blinded veterans who can tolerate a faster paced more demanding rehab program. The Clinic Program on the other hand is especially designed for those blinded veterans with multiple disabilities and medical problems which necessitate a more individualized and slower paced program. The number of beds operated by Clinics and Centers tend to vary. Below is a list of the eight programs, their location, and bed capacity.

BLIND REHAB CENTERS

1. The Western Blind Rehab Center, (WBRC) VAMC Palo Alto, CA (30 beds)
2. The Central Blind Rehab Center (CBRC) VA Hospital Hines, IL (30 beds)
3. The Eastern Blind Rehab Center (EBRC) VAMC Westhaven, CT (25 beds)
4. The Southeast Blind Rehab Center (SBRC) VAMC Birmingham, AL (30 beds) and
5. The Blind Center at VAMC San Juan, PR (This facility is currently an outpatient program, interim to completion of construction of a 120 bed nursing home care unit, in which ten beds have been designated for a blind rehab center.)

BLIND REHAB CLINICS

1. VAMC American Lake Tacoma, WA (12 beds),
2. VAMC Waco, TX (15 beds), and
3. VAMC Westhaven, CT. (15 beds planned; currently using 5 Center beds) This last facility has not yet been fully implemented and was transferred from VAMC North Hampton, MA effective October 1, 1986. Currently the clinic uses five beds designated for the center, so in reality the Center has only 20 beds

available to it rather than the 25 it is supposed to be authorized. Inasmuch as the Puerto Rico facility is not yet operational, it will be excluded from further discussion in terms of the remainder of this statement.

Since the opening of the first VA Blind Rehab Center at Hines 40 years ago, the BVA has been an extremely strong supporter of the VA program and is the first to say the VA program is the finest in the world. We were instrumental in encouraging the VA to assume the responsibility for the care and rehabilitation of war blinded veterans after World War II. Possibly for the first time, we are gravely concerned for the future of the Blind Rehabilitation Service in the VA.

2. Two weeks ago, the BVA conducted a telephone survey of the seven BRC's in the Continental U.S. and were very disturbed to learn that 698 blinded vets are currently on waiting lists for admission to Blind Rehab. The existence of a waiting list is not necessarily a concern to us, but the size is because it is an indicator of how long a veteran will have to wait before being admitted for training. We learned that a veteran may have to wait from three months to as long as fifteen months (See Appendix A) before admission, depending on the facility. There are a number of factors which are influencing the current waiting list that we feel are relevant to this hearing and therefore of interest to you.

2.1 The number of applications is increasing due to the rapidly increasing incidence of blindness in the aging veteran population. We have testified to this phenomena many times in the past, encouraging the VA to plan accordingly. For several years we have called for the construction of a new 30 bed Blind Center to be located at VAMC Dallas, TX.

2.2 All of the existing beds designated for blind rehab either are not now available or at some time during this past year have not been available due to staffing shortages. At least four of the programs have deliberately kept the bed census below capacity because they did not have sufficient staff to teach the vets. This has also resulted in longer length of stays because staffs have been stretched so thin. Blind rehab is a unique discipline requiring one to one teaching in order to maximize the learning experience for the blinded vets. Several factors have contributed to the staff shortages including recruitment and retention problems, cuts in FTEE in some cases and freezes on vacancies in others.

In the past, VA was the most attractive employer for Blind Rehab Specialists with Masters Degrees, but this is no longer the case. VA has serious problems competing with the private sector and state agencies for the most highly qualified professionals. The VA is also experiencing difficulty in retaining professionals because more attractive opportunities have presented themselves outside the VA. When vacancies do occur it takes much longer to fill them with qualified professionals, and lengthy delays may result in holding down the bed census.

2.3 Cuts in FTEE or freezes on vacant positions have also plagued several of the programs. EBRC for example, has suffered several cuts over the years, which have left them short staffed and they will be required to take an additional cut of 2.8 FTEE. American Lake currently has three vacancies they are not permitted to fill and as a result are only operating 9 of their 12

beds. Last FY Waco was only able to operate 10 of 15 beds due to problems in recruiting. CBRC also has experienced problems in recruiting, resulting in holding down bed census. The most glaring problem exists at VAMC Westhaven, CT. As mentioned above, the Clinic was transferred there almost two years ago with absolutely no prior planning. It had previously been a ten bed program at VAMC North Hampton and those beds and ceiling were transferred to Westhaven, supposedly to prevent the program from dying. As of this date, none of those beds are operational and the Clinic has limped along using five beds designated for the Center.

The Five Year Facility Plan for Westhaven Blind Rehab Service calls for a fifteen bed Clinic and a thirty bed Center, but that is down the road some three to five years. This is totally unacceptable and reflects a total lack of sensitivity to the rehabilitation needs of blinded veterans. This failure in planning has resulted in the Center having only twenty beds authorized which further delays veterans being admitted to the Center Program and in reality, due to staffing shortages, only 16 or 17 beds are operational. There is a crying need to accelerate the Five Year Facility Plan which would result in the activation of 20 additional beds. This is nearly the equivalent of establishing another Center. Currently between the two Programs there are 226 blinded vets awaiting admission and a service connected (SC) vet must wait 8 months and a non-service connected (NSC) vet must wait 15 months. We have no way of knowing just how many vets have refused referral because of the incredibly long waiting period and we were shocked to learn that 6 blinded vets have died while awaiting admission. Had those vets been admitted more promptly, and their total health care needs monitered during training they might be alive today.

2.4 Another factor which has significantly impacted the length of the waiting list has been loss of FTEE at various facilities or the freezing of vacant positions. Although the Blind Rehab Program is regional in nature, the local Medical Center has to bare the full financial responsibility for the program. Also when a local VAMC is required to make cuts in FTEE, those housing BRC's have expected the BRC to take a full hit along with other services. We feel very strongly that because of the regional nature of the BRC program, any cuts should be shared by the entire region. This would minimize the impact on the blind program enabling it to operate at full capacity. In fact, Mr. Chairman, the VA does have a Circular 10-87-117, dated October 6, 1987 (See Appendix B), that directs this very kind of distribution of cuts. Unfortunately, the VA seems to be ignoring its own directives when it comes to Blind Rehabilitation.

2.5 The special training needs of blinded veterans, enrolled in either vocational or educational training or employed for computer evaluation and training, also are contributing to the time all applicants must wait for admission to WBRC and CBRC. These two Centers are attempting to offer informal, within existing resources, a Computer Evaluation and Training Program (CETP) and have set aside two beds that have been designated for the regular adjustment to blindness program. Consequently, they have two fewer beds operational for the vast majority of veterans applying for the regular program. BRS submitted a proposal last FY that would provide for the establishment of two formal CETP in FY89 and two in FY90. The proposal called for 5 additional FTEE for each program in addition to 2 additional beds. This proposal was denied by VACO in the budget submission. A similar request has once again been made by BRS in the FY89 budget request, but we have little hope it will be

approved. It appears likely that all new spending submissions will be reached regardless of merit. We feel that the CETP should be funded on merit alone, but the fact that it is also contributing to the long delays at the Blind Centers, reinforces the importance of establishing formally, such programs.

2.6 Construction projects at WBRC this year and EBRC last year have necessitated closing some beds during the project. These were necessary projects and we do not argue with the delays which they may have caused. Other Centers tried to help out by accepting some of the veterans to reduce the delays and this was greatly appreciated.

3. As indicated above, recruitment and retention of highly qualified professionals has played a significant role in the problems confronting Blind Rehab Service. The VA has taken very positive action on two fronts in an effort to alleviate these problems.

3.1 They have approved Special Salary Rates for both the WBRC and EBRC. Both facilities feel this has helped immensely in their recruitment efforts. CBRC has not been so fortunate in that their request was rejected for lack of funds to support it. Now they find themselves, the "Grandaddy" of Blind Rehab, at a disadvantage in competing with its sister Centers for qualified professionals. We are hopeful that their request will be resubmitted and approved for the new FY.

3.2 The other initiative being pursued by VA is to upgrade Blind Rehabilitation Specialist positions, making them more attractive for recruiting and offer more in terms of long term career advancement opportunities.

We are encouraged by both of these initiatives, but they will mean nothing if positions continue to be cut or frozen.

3.3 Additionally, when cuts are absolutely necessary, they should be spread across the region to minimize the impact on special medical programs like Blind Rehab.

4. All is not well, Mr. Chairman in terms of availability of beds for blinded veterans, and there certainly is a strong demand for these services as can be seen by the numbers of veterans awaiting admission. We cannot stress strongly enough the importance of this training for the successful adjustment of blinded veterans. It is extremely difficult for me to adequately express just how important blind rehab was for me following my loss of vision in Vietnam. Suffice it to say without that training, I would not be here before you today. Can we afford to deny this kind of service to the thousands of other blinded veterans who can indeed benefit, If they are to get off pension roles and become tax paying citizens once again, Blind Rehab is the starting point before one can seriously consider vocational or educational rehabilitation. The VA has been the pioneer in the field and has served as the model world wide for Blind Rehabilitation. We need the help of Congress to maintain this position of leadership and excellence.

Again, Mr. Chairman, I want to thank you for holding this important hearing today and inviting us to testify. We hope our input will be helpful to the Committee, and as always I would be pleased to answer any questions you might have.

APPENDIX A

	BEDS			WAITING PERIOD	
FACILITY	AUTHORIZED	OPERATING	NO. WAITING	SC	NSC
CBRC	30	29	75	4 MO.	4 MO.
EBRC	25	17	176	8 MO.	15 MO.
SBRC	30	30	138	4 MO.	4 MO.
WBRC	30	30	142	3 MO.	10 MO.
AMERICAN LAKE	12	9	67	6 MO.	6 MO.
WACO	15	15	50	3 MO.	3 MO.
WESTHAVEN		5	50	12 MO.	12 MO.

APPENDIX B

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

CIRCULAR 10-87-117
October 6, 1987

TO: Regional Directors; Medical District Directors; Directors, VA Medical Center Activities, Domiciliaries, Outpatient Clinics and Regional Offices with Outpatient Clinics

SUBJ: Blind Rehabilitation Centers and Clinics (RCS 10-0773)

1. PURPOSE: The purpose of this DM&S Circular is to provide designated VA facilities with policy guidelines regarding Blind Rehabilitation Centers and Blind Rehabilitation Clinics. This includes organizational alignment, specialized nature of programs, staffing requirements, blind rehabilitation staff roles, application procedures, admission and reporting requirements. This DM&S Circular is a new permanent issue and will be incorporated into M-2, Part I, by expiration date.

2. BACKGROUND: Blind Rehabilitation Centers were established to provide comprehensive adjustment to blindness training in a residential setting to blind veterans. The Centers also offer special programs including low vision training, electronic reading aid (ERA) training, electronic travel aid (ETA) training, and evaluation and training with computers/computer assisted devices. The Blind Rehabilitation Clinics were established to provide adjustment to blindness training and services to those blind veterans who have additional problems (i.e. psychological, medical, social, etc.) which prevent them from participating in a Center program. Each Center and Clinic provides a specialized program and serves as a resource to a multi-region catchment area.

3. POLICY:

a. In a health care facility where a Blind Rehabilitation program currently exists or is to be established, the program will be established as "Blind Rehabilitation Service (124)" reporting to the Chief of Staff. The Chief of the Service will be a blind rehabilitation specialist who will have operational and programmatic responsibility for the program. A physician will be assigned to the Service with responsibility for the health care needs of the blind veterans participating in the program.

b. In a health care facility where a Blind Rehabilitation Center and Clinic exist, both will constitute the Blind Rehabilitation Service with the Chief of the Blind Center being the Chief of the Service. However, the Center and Clinic will be physicially separated. This separation will include patient rooms, day rooms and skill teaching areas. Common utilization of the Low Vision Clinic is appropriate.

4. ACTION:

a. Specialized Nature of the Program: VA Blind Rehabilitation Centers and Clinics will offer a highly specialized rehabilitation program in a residential setting to blind veterans. Each facility will serve a multi-region area (see Attachment A) and employ a staff skilled in this unique discipline. Because of the unique nature of the program, teaching on a one-to-one basis must be maintained.

THIS CIRCULAR WILL EXPIRE OCTOBER 6, 1988

b. Recommended Staffing: In order to accomplish the mission of Blind Rehabilitation, recommended minimum staffing limits are: Centers—1.6 staff per bed, Clinics—1.2 staff per bed. (Training at Centers consist of six one hour periods daily. The Clinics are smaller units and the severity and nature of the Clinic patient's condition generally results in 20-30 minute training segments. This permits more flexibility in staff/patient scheduling and allows a lower staff/patient ratio.) These minimum limits must be met in order to ensure quality care and optimal length of stay. Because of the multi-regional nature of the programs, any proposed staffing reductions due to decreasing resources should not be imposed on the Center or Clinic. The reduction shall be dispersed throughout the multi-region service area to minimize the impact. In facilities where past reductions have occurred, efforts will be made to restore the staffing to previous levels.

c. Role of the Staff at a Blind Rehabilitation Center/Clinic: The role of the blind rehabilitation staff is to assess rehabilitation needs, develop and implement individual rehabilitation plans, coordinate support services in a team approach and make recommendations to referring facility concerning rehabilitation program follow-up.

d. Application, Procedures and Admissions: All applications for blind rehabilitation will be sent to the Blind Rehabilitation Center nearest to the referring VA facility. An Application Review Committee will determine whether the applicant is a Center candidate or a Clinic candidate. The committee will be chaired by the Blind Center Assistant Chief and will act as a multidisciplinary advisory group consisting of the Blind Center's physician, nurse, psychologist and social worker, with consultation from psychiatry as needed. The Application Review Committee will refer appropriate Clinic candidates to the Clinic nearest the referring facility. All applications rejected by Clinics will be forwarded to Central Office Blind Rehabilitation Service (124) for further review.

e. Admissions: All blind veterans are eligible for admission to a Blind Center or Clinic if they can benefit from the program. Blind veterans may benefit in varying degrees from blind rehabilitation according to their limitations caused by other mental or physical problems. The Chief of the Clinic will make the determination whether the veteran has the potential to benefit from this program or not. This will be done with consultation and advice from the physician and nursing staff regarding any medical conditions that may exist. Those applicants who are questionable will be admitted for an evaluation period in order to assess the potential rehabilitation benefit that might be expected.

f. Reporting Requirements:

(1) The Blind Rehabilitation Centers and Clinics will submit RCS 10-0086, a Quarterly Report of Blinded Veterans and Blinded Military Personnel who Receive Blind Rehabilitation at a VA Blind Rehabilitation Center or Clinic.

(2) The Blind Rehabilitation Center and Clinic Chiefs will submit a semi-annual statistical report to the Director, Blind Rehabilitation Service (124), Central Office. See Attachment B. RCS 10-0773 is assigned to this report.

CIRCULAR 10-87-117
October 6, 1987

5. REFERENCE: M-2, Part I, Chapter 18.

6. RESCISSIONS: This DM&S Circular will be rescinded. October 6, 1988.

7. FOLLOW-UP RESPONSIBILITY: Assistant Chief Medical Director for Clinical Affairs (124).

Arthur J. Lewis MD
ARTHUR J. LEWIS, M.D.
Deputy Chief Medical Director

Attachments

DISTRIBUTION: COA: (10) only
SS (124) FLD: RD, MDD, MA, DO, OC & OCRO-1 each plus 200-2
EX: Boxes 44-6 & 88-2, Boxes 104, 60, 54, 52-1 each & 63-5

CIRCULAR 10-87-117
October 6, 1987

ATTACHMENT A

The Blind Rehabilitation Centers are located at VAMC's:

Birmingham, Alabama	serving Regions 2, 3 and 7
Hines, Illinois	serving Regions 2, 4 and 5
Palo Alto, California	serving Regions 5, 6 and 7
San Juan, Puerto Rico	serving Region 1 (Puerto Rico and Virgin Islands)
West Haven, Connecticut	serving Regions 1 and 2

The Blind Rehabilitation Clinics are located at VAMC's:

American Lake, Tacoma, Washington	serving Regions 5, 6 and 7
Waco, Texas	serving Regions 3, 4, 5 and 7
West Haven, Connecticut	serving Regions 1, 2, 3 and 4

CIRCULAR 10-87-117
October 6, 1987

ATTACHMENT B

BLIND REHABILITATION
SEMI-ANNUAL REPORT
(Reporting Period)

I. Total Admissions

II. Programs

A. Regular

B. Other

1. ETA

a. List type

2. ERA

a. List type

3. Computer

a. List type

III. Average Daily Census

IV. Occupancy Rate

V. Turnover Rate

VI. Average Length of Stay

A. Regular

B. Other

VII. Average Age

VIII. Age Range

0-19
20-29
30-39
40-49
50-59
60-69
70-79
80-89
90-00

CIRCULAR 10-87-117
October 6, 1987

IX. Veteran Status

A. Service-connected

1. Blindness

2. Other

B. Nonservice-connected

1. A&A

2. Pension only

3. Peacetime (or no pension for other reasons)

X. Period of Service

A. WW I

B. Post WW I Peacetime

C. WW II

D. Post WW II Peacetime

E. Korean

F. Post Korean Peacetime

G. Viet Nam

H. Post Viet Nam Peacetime

I. Military

XI. Admissions by State

A. List

B.

C.

BLINDED VETERANS ASSOCIATION

477 H STREET, NORTHWEST • WASHINGTON D.C. 20001 • (202) 371-8880

September 16, 1988

The Honorable G.V. "Sonny" Montgomery
Chairman, House Veterans Affairs Committee
335 CHOB
Washington, DC 20515

Dear Mr. Chairman,

On behalf of the Blinded Veterans Association (BVA) I want to thank you for holding the important hearing on Veterans Administration Health Care on September 7, 1988. Once again, we appreciated the opportunity to express our views on the VA statistics, policies and administration of hospital bed levels and the impact of shortages of health care professionals on the quality and quantity of health care being delivered.

As the hearing unfolded, one could not help be impressed by the magnitude and complexities of the problems confronting the VA Department of Medicine and Surgery (DMS). Clearly all is not well with DMS and VA health care delivery and the problems have in fact reached crisis proportions. One could also not help being impressed by the caliber and obvious dedication of the many witnesses who testified before the committee. Additionally, I must commend the dedication, interest and concern expressed by all the members of the subcommittee. It was indeed refreshing to finally see an open, candid exchange regarding the true nature and depth of the problems faced by DMS and hopefully, the establishment of a truly collaborative and cooperative effort to find reasonable solutions.

After listening carefully to all the witnesses and reflecting on the issues, problems and questions that were raised, I felt compelled to write this letter on behalf of our nation's blinded veterans. In our testimony, we outlined in detail how staffing shortages and diminishing resources are impacting blind rehabilitation services as provided by the VA. We particularly stressed the fact that currently there are over 700 blinded vets awaiting admission to the blind rehab facilities and the list and length of wait continues to grow rapidly. We went on to highlight the factors contributing to this serious problem. I will not rehash that data here Mr. Chairman, but I do want to try and place it in the context of the crisis being faced by DMS.

Clearly, the system is not in good shape with only a few facilities not facing difficulties. The global picture is obviously very strained and without decisive, corrective action soon the entire system will begin to collapse.

In attempting to place our concerns for blind rehabilitation in the VA into the context of the acute problems confronting the greater system, my fears for the future of VA blind rehabilitation and the welfare of blinded veterans were heightened. When one examines the entire system with normal vision, the picture is unmistakable. Serious problems exist and blame cannot be laid at any one doorstep. The factors leading to the current situation are many and indeed complex. There will be no quick fixes or easy solutions. In the

absence of a dramatic infusion of resources, significant and painful cuts will have to be made and have already begun. The preservation of the system capable of delivering quality services must be the highest priority to ensure the viability of the small special medical programs.

When we view the problems confronting blind rehabilitation services with tunnel vision, as we are often proned to do, it is difficult for us to imagine an agency the size of the VA being unable to provide the necessary resources to operate a viable, dynamic blind rehab program. If we look at a system that maintains 90,000 beds and a staff of over 194,000, it seems inconceivable that blind rehab consisting of only 175 authorized beds cannot be kept operational and adequately staffed, or that blinded vets should have to wait over a year for admission. How do we explain this to our blinded veteran constituents?

Cuts in FTEE made across the board may not seem to be large in comparison to 194,000 employees, but just a few cuts in small special medical programs like blind rehab can be devastating. The Eastern Blind Rehabilitation Center (EBRC) VAMC Westhaven, CT is an excellent example in point. The Center has suffered a number of cuts over the past few years and has been advised they will incur a further cut of 2.8 FTEE. The EBRC is in critical condition for a number of reasons and if appropriate action is not taken soon, it may not be possible to salvage it. The Blind Rehabilitation Clinic at VAMC American Lake is another excellent example of a program in serious trouble.

Hopefully, Mr. Chairman, I am not over reacting, but I must ask the question. Are small special medical programs for severely disabled veterans expendable in order to preserve the system? Are these services to be severely curtailed to the point that most eligible veterans will be unable to get what they are entitled to?

Let me say it another way, Mr. Chairman. Fortunately, the number of blinded veterans is extremely small in comparison to the 28 million veterans in our nation and fortunately blindness in and of itself is not fatal. I submit Mr. Chairman, that blindness can be a malignancy that relentlessly eats away at one's self-esteem, self-confidence, worth, dignity and independence. The bad news is there is no cure for blindness, but the good news is there is a highly successful treatment, blind rehabilitation, that will not only arrest the malignancy, but reverse the affects, restoring self-esteem, confidence, worth, dignity and independence, enabling that veteran to resume his rightful place in society.

The VA blind rehab program began 40 years ago and has enjoyed remarkable success. The VA has truly been the pioneer in the field of blind rehabilitation and indeed serves as the model world wide for blind rehab. The contributions to the field of blindness are unparalleled, but we are concerned that this marvelous record of accomplishment may be in jeopardy. The BVA has been a strong supporter of the VA program and not a day goes by that we are not working with newly blinded veterans extolling the virtues and advantages of blind rehab and encouraging them to apply to the VA for the finest training available in the world. We cannot afford to lose such an invaluable asset to the rehabilitation of blinded veterans. It may sound as though I am requesting a giant band-aid be applied to blind rehabilitation service to stop the bleeding at the expense of the total health care delivery system. This is not the case. The acute problems facing VA blind rehab are symptomatic of the

greater problem affecting the entire system. To properly preserve the programs and services especially designed for blinded veterans, the entire system must be preserved. If the entire system is not healthy, the band-aid applied to blind rehab surely will not last.

Mr. Chairman, my intent has not been to be melodramatic and I hope I have not over reacted, but I felt compelled to advise you of our grave concerns, not only for the future of blind rehabilitation, but the entire VA health care delivery system. The survival of our programs and services is dependent on the health of the total system.

Again, I congratulate you for holding this hearing in such an expeditious manner and for your long support for veterans. Hopefully the dialogue opened will lead to reasonable solutions to the critical problems facing DMS. As always, BVA pledges its support and efforts to working with you in any way possible to facilitate finding and implementing solutions.

Very Sincerely,

Thomas H. Miller
Director of Governmental &
Community Relations

STATEMENT OF

VIETNAM VETERANS OF AMERICA, INC.

Presented By

THOMAS A. SHERWOOD
DIRECTOR, HEALTH POLICY & PLANNING

before the

HOUSE VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

on

DEPARTMENT OF MEDICINE AND SURGERY RESOURCES

SEPTEMBER 7, 1988

Mr. Chairman and members of the Committee, the Vietnam Veterans of America, Inc. (VVA) appreciates the opportunity to present it's views on the VA Health Care System. During the last fiscal year and this fiscal year we have had the opportunity to assist the VA Health Care System (VAHCS) in some growth and development. We believe that the system, perhaps for the first time in many years, or even for the first time, is under scrutiny for the health care (HC) product it delivers directly to the veteran patient. We, as many others, have noted the many favorable contributions the VAHCS has made to the veteran and to the public at large in areas of biomedical research, AIDS care, medical education and to prosthetic and orthotic advancement. We have taken note of the VAHCS acceptance of some risk in exposing itself to the public and increasing its dialogue with the Veteran Service Organizations (VSO). For this we credit Dr. John A. Gronvall, Chief Medical Director (CMD). Given the incentives against interacting with the veterans community and the impossibility of achieving any true field-level individual accountability in such a large highly centralized system, Dr. Gronvall deserves a salute and our full support in terms of what he has been able to accomplish.

However, during the last two years we have also seen just how difficult it is for the highly centralized VAHCS to manage the quality and maintain the product of health care at any given VAMC. In fact, they cannot. Testimony, investigations, and the like, whether from the Chairman of an Oversight Committee on the subject of phantom beds and elusive staff, or the GAO's questions about the quality of care, or the general inquiries of the VA as to why they would desire to either eliminate or underfund health programs that help veterans at the expense of solid clinical strategies, or even from the press reporting on a medical center director having decided to deny a group of veterans health care, all point to a system that has sacrificed its mission in favor of its own centralized bureaucratic enertia.

In a letter sent to the Chairman of this committee earlier this year, we pointed out that the single most pressing problem or issue for the VAHCS is the questionable quality of health care at the medical center level. The inability to control, direct, and manage the medical center from the medical center itself is creating serious problems. Given all of the oversight by management above the medical center director level, the system has now become dangerous for both veteran patient and VAMC management. The situation has lead to a kind of institutional paralysis where the director and key staff dare not engage in decision-making without checking with "CO", "Operations", "Regional", or "Resources". Clearly the best recognition of this devastating problem is the creation of the Management Efficiency Pilot Program (MEP), an experimental program which allegedly allows five VAMC's to operate relatively independent of the centralized hospital system. This experiment is intended in part to determine if VAMC's can do a better job without the heavy handed interference of Central Office. Unfortunately in this experiment while these VAMC's may have some control over their staff ceilings, they certainly have no control over the resource allocation system or methodology (RAM) which determine if these centers are losers or winners. If they are winners - as in the majority of these cases, they are not allowed to keep all of their gains. This brings about the very lack of management flexibility intended. In short, the MEP is a failure. It is our belief that most if not all of the quality of care issues come down to a matter of local management. Currently the VAMC's are unable to be held accountable or be given the authority and responsibility to properly manage.

It is our further belief that the VAMC's should be given direct responsibility for managing all of their appropriated health dollars. At present, too many appropriated resources are absorbed by the Regions and Districts for administrative staffing and bureaucratic gamesmenship. Without converting

the VAHCS into a truly decentralized system, management decisions will continue to be made by those furthest from the patients and the continuing result will be poor care and unmet needs. The balance to this testimony will offer recommendations which we believe can facilitate decentralization. Additionally, we will make some recommendations designed to promote greater VAMC staff sensitivity to the relationship between service connection and eligibility for health care. These in turn should facilitate better attitudes and compassion in the medical care staff and produce a better health care product.

When the Chairman of this committee asked some months ago what was the most pressing issue effecting the VAHCS, we responded by saying that it was the quality of care. It still is! As we all now know, the means test has been used by some VAMC's to turn veterans away. Others have used the RAM for the same purpose. Under the circumstances, shrinking resources can no longer be ignored. Yet the Administrator has appeared in the media stating that the VA is delivering more and better health care in spite of resource limitations.

Nevertheless, we know that the VA has projected a shortfall of better than $600 million for FY89 in its health care budget. As you know, for example, Department of Medicine and Surgery Health Care Region I (DMS HCR) has lost as much as $10 million on its target allowance while Region 7 has gained $8 million on its target allowance. That one region can gain and another region can lose so much while both share essentiallly the some needs make no sense whatsoover.

The five Management Efficiency Pilot hospitals cited above are fully subject to the VACO directed RAM system which limits control over their personnel ceilings. This bodes poorly for the success of the experiment, but the remainder of the VAMC's are in even worse condition having virtually no sense of ownership over their resources. Necessarily, the patient consumer has no say in the matter

whatsoever. Quality care at times is available in the VA, but this is more by accident than by VACO design. The good care that is available in the VA is afforded not because of but in spite of the interference and meddling of the Regions whose big Quality Assurance, Utilization and Review, Computer, and Education and Clinical Affairs staffs consume so many resources. The VAMC's are reeling under the management pressure of the Regions, the Districts, VACO, the Medical Affiliates, the local community, the press, the Veteran Service Organizations, the Congress, and a myriad of competing regulatory forces at all levels. This has the effect of subordinating quality health care to bureaucratic and political survival. Upon discussing these problems with VAMC personnel, the record of some Medical Centers is one of day to day struggling just to carry the work load, struggling to reduce the excessive influence on the VAMC's in day to day operations, struggling to dampen losses under the RAM and struggling to keep low visibility but necessary health care programs such as in alcoholism, drug detoxification, contract Half-Way housing, and PTSD and struggling to simply manage the unmanageable.

VAMC Management

VA Central Office officials will tell you that the VAMC medical center directors (MCD's) enjoy a decentralized decision-making process and are in charge of their hospitals. They will also tell you that, with regard to RAM outcomes and Medical Center programs, VACO has a laisee faire policy. What they fail to acknowledge is that there are 7 Medical Regional Offices who determine and dictate what the VAMC's get under the RAM and who "take the heat" for VACO. This enables the VACO to say they don't make local VAMC decisions. Since these Regional Offices serve at the bidding of VACO, decisions are based on political priorities and agenda rather than clinical priorities. Is it any surprise then that the Regions have yet to devise a Quality Assurance program which can or

will ascertain the impact of the RAM on the quality of clinical care?

Because of these Medical Regions, VACO makes no clinical commitment to the VAMC's. The VACO and the Regions, whether or not by design, actually sponsor competition between Medical Centers based on a RAM system driven not by the clinical needs of veterans but by a zero sum resource allocation game carried out in the name of productivity and efficiency. The VACO is fond of saying that the Medical District Initiated Peer Review System is maintaining the quality of health care. Unfortunately, it appears that in the various districts where these systems are in place, they are doing different things without standards or consistency and none of them are looking at the RAM impact on the quality of care to any significant degree. The sad result is that some Medical Center Directors are now desperately forced to produce weighted work units at any cost to include, for example, the logging of flu shots as ambulatory surgical visits and turning away veterans desiring "non-productive" services. VA officials also state that the RAM does not generate new dollars and that the RAM should not be used to justify programs. But try to tell that to a Medical Center Director who loses hundreds of thousands of dollars on his/her adjusted target allowance, and see what impact such a loss has on programs and direct patient care.

As we have noted in our letter to the Chairman identifying the quality of health care as the single most pressing issue facing the VAMC's today, the Medical Center Directors are unable to operate free of outside interference from VACO. Instead, they can only react.

Recommendations

* Total health care coverage should be provided for all service connected conditions as well as for adjunct

conditions. The Means Test should apply to all non -service connected conditions. For example, a veteran service-connected at 10% for a skin condition should receive total health care coverage at no cost for that skin condition as well as for service-connected adjucnt conditions. The same veteran, however, should be Means tested for all other health care problems unrelated to those service-connected conditions. In another example, if a veteran is 50% service connected for a neuro psychiatric condition and the physician determines that the patient's physical complaint is related to the neuro psychiatric condition, the physical condition should be treated as an adjunct condition and the means test should be waived.

* All Congressionally mandated special programs such as the Center for PTSD Recovery, Geriatric Research, Education and Clinical Centers (GRECC) and the proposed Mental Illness Research, Education and Clinical Center (MIRECC) should either be exempt from the RAM or totally subject to the RAM, but not both or some combination.

* To preserve and vigorously support the DRG/RAM application for psychiatry without ignoring the diversity of psychiatric diagnosis, and all of the diagnostic gradations therein, the DRG/RAM for psychiatry must be more realisticly structured. The attached 1983 study

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conducted at Coatsville VAMC attempts to discern nursing workload based on proposed psychiatric diagnostic groups. (See attached study). In 1983 the Chief Nurse pointed out that there was a greater variation in work resource requirements in the care of the mentally disabled than are normally programmed for in the VA.

* Create a governing board of veteran consumers at each VAMC. The board functions should include but not be limited to:

  i Holding the VAMC Directors explicitly accountable for clinically based management of the VAMC and for the provision of quality care in all areas.

  ii Participation in all major decisions in the management of the VAMC, particularly if it relates to resources, affiliations, programs and key clinical and administrative appointments.

  iii Participation in policy implementation when VACO urges adjustments concerning health matters.

* Allow the VAMC to initiate and design its own annual budget plan first. The VAMC should do this within the DRG/RAM rules, but the Medical Center Director should be required to justify his/her budget requests by tailoring VAMC resource needs

to the veterans it serves and relative to the specific needs of the community where it is located. This may mean the VAMC will have to contract for some services and/or sell other services to sharing hospitals or health systems in that same community. The relationship between the VAMC and the VACO should be one in which the VAMC sells services to VACO and VACO pays the medical center to provide services for veterans.

* The DM&S Medical Regions must be eliminated. Other than draining resources from the Medical Center level, and serving as a launching pad for internal VA political advancement and interference regarding Resource Allocation, these Regional Offices make few valuable contributions to the well-being of the VAMC or the patients the VAMC is supposed to serve. The DM&S Regional Offices serve only to allow the VA Health Care System to say it is decentralized when in fact it is not.

* Both the DM&S personnel ceiling (and floor) should be eliminated altogether. Maintaining a national level of 194,000 plus health care FTEE without attending to the individual VAMC work loads ignores reality at the local health care delivery level. Such a national ceiling forces top down management to the eventual peril of the veteran in want of quality medical care. Instead, each VAMC should be allowed to justify its own staffing needs based on what is required to get the job

done. Among the many problems with centralized management which imposes a national ceiling is that the system cannot adjust to its actual staffing numbers as program needs, workload and bed occupancy rates change. This principle is acknowledged in the 5 Hospital Management Efficiency Programs where there are no ceilings and the Director hires in accordance with program need and resource availability. This is a local management issue, not a national one.

* The 90,000 bed ceiling should be eliminated altogether. Like the personnel ceiling, this too has been a failure as a management tool. The recent House Committee review has clearly demonstrated that serious problems have developed in which there are phantom beds, beds counted but out of service due to staffing shortages, beds counted but out of service due to construction, beds sometimes counted and sometimes not but which are simply out of use and/or awaiting transition. It would appear that the VA is unable to determine how many truly operating beds, from a planning perspective, are actually operational in the centralized system. This is an issue for local management, not national. The individual medical center, must be allowed to size itself based on health needs, determined at the local level, rather than by the central office.

* After Congress appropriates the dollars

for veteran care, the VA should be using those dollars to purchase health care from the VAMC's. The VA needs to become a fiduciary intermediary at the national level and the VAMC's should be given the opportunity to provide these services in exchange for a budget to operate the health care component based on the DRG/RAM system. This relationship between the VA fiduciary intermediary and the VAMC provider needs to be direct, above board, interactive, politically diminished, patient centered, and driven by the desire to provide a quality health care product. The VACO role should be based on national clinical and administrative standards designed to provide the necessary guidelines and constructive support, both technical and professional, to the VAMC in order to facilitate the guarantee of a good product.

* The time has come for veteran customers, as users of the VA health system, to be assured that Medical Center Directors have both the education and experience to manage their hospital systems. Traditionally, VA Medical Center Directors have come from all disciplines such as personnel, engineering, medicine, administration, social services, supply, recreation, pharmacy, nursing, etc. We strongly recommend that regardless of what the discipline, the Medical Center Director have a graduate credential in health management systems. A few examples include Public Health Administration,

Hospital Administration and Health Institutions Policy and Planning. Further, these health professionals should belong to a professional organization such as the American College of Health Care Executives or an accredited health care organization for which there is continuing education relative to current developments in the health care management and delivery fields. Even though having such credentials and belonging to such organizations offers no guarantee of competence, the exposure to the issues associated with operating health systems in the VAHCS can go a long way toward assisting the VA Medical Center Director in managing a complex health care system. Moreover, VAMC Directors meeting these standards and with the full responsibility and authority to create and manage their own budgets and facilities should be an improvement.

* Marketing and outreach strategies should be implemented as a means for forcing the VAMC's to deliver a better product. The VA almost hides from those it serves and therefore has no means of accountability for what it does. If the VA is concerned that too many aging service connected veterans in this country will suddenly flood the system, then it may be appropriate to authorize the service connected veteran to use a health provider of his or her choice at VA's expense.

Mr. Chairman, some of these recommendations will appear too bold. Nevertheless, is it too much to ask that the American veteran be given an opportunity to assure quality by managing his or her own system? We think not.

Mr. Chairman, this concludes our testimony.

Veterans Administration

Memorandum

Date 11-31-83

From: Chief, Nursing Service (118)

To: Medical Center Director (00)
THRU: Chief of Staff (11)

Subj: Staffing

1. There is an acute nursing shortage at Coatesville Veterans Administration Medical Center due to the totally inadequate FTE ceiling allocated to Nursing Service. As of 9/30/83 there were 146.4 (FTE) staff nurses, 85 (FTE) LPN's and 371.2 (FTE) nursing assistants providing direct patient care. Asking these personnel to provide quality care to over 900 deserving veteran patients 24 hours/day, 7 days/week is unreasonable in light of present day standards.

2. Specifically one requirement of the agency supporting the JCAH standard of individualized treatment protocols for every patient is that in fact the agency meets that standard. That standard requires that the psychiatric patient be treated in the same manner as the surgical patient i.e. individually not as a "herd of the same". The implication of this standard is clear: the staffing "game rules" for psychiatric facilities which formerly allowed very low staff/patient ratios must change.

3. We are simply not providing good patient care. Personnel are "burned out", overworked and frustrated. Some patient falls, some patient to patient assaults, some patient to employee assaults, some patient elopements, and some patient regressions can be attributed to lack of staff. (Please refer to Appendix I "Substantiating Patient Data".) In light of the patient care mix and the increased work load, the allocation of additional nursing personnel to Nursing Service at C.V.A.M.C. is mandatory.

4. This proposal defines the type of nursing care that should be provided to the patient population at C.V.A.M.C. The FTE direct care requirement was calculated based on providing minimal and optimal care. A mid-point direct care FTE was also determined. The total FTE direct care requirement for providing minimal, midpoint and optimal care is as follows:

Total FTE Requirement

Minimal	Midpoint	Optimal
1073.5	1437.9	1802.3

5. Therefore, this proposal is submitted in demonstration for the need for additional nursing staff at C.V.A.M.C. The nursing ceiling at C.V.A.M.C. is 660.8 FTE. Approximately 36 FTE are required for administrative, educational and specialty positions such as Infection Control and Quality Assurance Nurses. A synopsis of the additional nursing direct care FTE requirement at the minimal, midpoint, and optimal levels is as follows:

Total Additional FTE Nursing Requirement

Minimal	Midpoint	Optimal
448.7	813.1	1177.5

6. The specific request for additional direct care nursing staff at C.V.A.M.C. is 813.1 FTE based on the midpoint level.

THOMAS A. SHERWOOD, R.N.

INTRODUCTION

Historically health care facilities have been identified with treating certain prototype patients. This proposal identifies the 13 prototype patients at Coatesville VA Medical Center, defines the care required by each prototype in the form of nursing interventions, allocates an optimal, minimal, and midpoint time factor to the intervention(s) and computes the nursing FTE requirement to provide such care. (Please refer to Appendix II "Explanation of Terms & Calculations".)

A synopsis of the Average Daily Patient Census (A.D.P.C.) of each prototype group, the Nursing FTE Requirement Per Prototype Patient, and the Total Nursing FTE Requirement Per Prototype Group is:

		A.D.P.C. of Prototype Group	Nursing FTE Requirement Per Prototype Patient (Based on Midpoint Level)	Total Nsg. FTE Requirement Per Prototype Group (Based on Midpoint Level)
1.	The Acute Psychiatric Patient	150	1.79	269
2.	The Intermediate Psychiatric Patient	170	1.08	183
3.	The Chronic Psychiatric Patient	132	1.56	205.6
4.	The Substance Abuse Detoxifying Patient	20	1.62	32.4
5.	The Substance Abuse Rehabilitation Patient	90	0.84	75.6
6.	The Post Traumatic Stress Disorder Patient	13	1.23	16
7.	The Pre Outplacement Patient	49	0.5	24.9
8.	The Acute Medical Patient	* 5	2.96	14.8
9.	The Medical Patient	* 71	1.83	130.5
10.	The Geriatric Patient	201	1.23	246.2
11.	The Alzheimers Patient	20	1.28	25.6
12.	The Chronic Neurological Patient	29	1.51	43.9
	(Inpatient) Total	950		1267.5
13.	The Ambulatory Care Patient (Outpatient)	125	0.19	23.4
	New N.H.C.U. (Geriatric)	* 120	1.23	147.0
	GRAND TOTAL =	1195		1437.9

*NOTE: A.D.P.C. was not utilized. In these instances current or projected operating beds were utilized to determine the required nursing FTE because of the temporary closure of beds and the projected opening in December 1983 of the new Nursing Home Care Unit.

Implementation of the proposal would enable Nursing Service at Coatesville VA Medical Center to provide better nursing care to the entire patient population. Currently patients are either not receiving the appropriate care or the provision of that care is at such a minimal level that it could be considered non therapeutic.

Examples of direct and indirect care that patients at Coatesville VA Medical Center are not receiving because of the nursing staff shortage include the following:

1. Patients are not receiving individualized attention; the special needs of each patient cannot be consistently met resulting in fragmented or imcomplete care.

2. Patients are not given the opportunity to interact enough with staff; patient problems are not identified and resolved adequately, patients cannot express their feelings, staff cannot assist the patient in dealing with anxiety, hallucinations or delusional thinking.

3. Patients are not receiving sufficient amounts of care that is prevention oriented prior to crisis situations when there is a potential for acting out or violent behavior.

4. Patients are not receiving adequate amounts of supervision and observation on the off-tours of duty, weekends and holidays.

5. Patients are not being initially, consistently, or continually re-assessed both mentally and physically for revision of their treatment plans.

6. Patients are not receiving the full benefits of planned socialization groups, activities, off station trips and other therapeutic modalities such as Reality Orientation.

7. Patients are not receiving enough assistance in Activities of Daily Living; there is an insufficient number of grooming groups, patients are not being fed in an unhurried manner, turning and ambulating patients is not as frequent as required and the initiation of such specific patient programs such as bowel and bladder re-training is hampered.

8. Patients are not receiving enough required information in the form of patient education in regard to their medications, treatments, etc.

9. Patients are not being adequately prepared for discharge into the communit basic living skills such as menu planning, simple food preparation, bed-making or money management cannot be taught to the patient on a consistent basis.

10. Patient's families are not being interacted with on a consistent basis tr enlist their support and assistance for the patient or to provide them w support, education and re-assurance from a nursing perspective.

11. Patient's clinical records do not sufficiently reflect the actual status of the patient thus having a direct impact on Quality Assurance Reviews and an indirect impact on patient care.

12. Patients are often "lost" within the multiplicity of services provided; often privileged patients do not attend scheduled therapies, etc. Nursing Service does not have sufficient time to provide the required coordination and follow-up in such instances.

In reviewing this proposal there are certain considerations that must be kept in mind. The prototype patient as described is the "typical" patient. Within each prototype group, there are patients who require more nursing hours per patient day and there are patients who require less nursing hours per patient day. For example, the identified midpoint NHPD for the Acute Psychiatric Patient is 10.25; in those instances, which are frequent, where a patient is placed on Suicidal Status, continous 24 hour observation by an identified member of the nursing staff is required. If a newly admitted psychiatric patient is not acutely psychotic, the number of NHPD may be less than 10.25. Throughout the proposal each nursing intervention is timed; a range is provided from the optimum amount of time required to the minimal amount of time required. The midpoint was utilized to determine the required FTE.

In some instances interventions can be done simultaneously. The determination of the viability of performing simultaneous interventions must be based on the clinical judgement of the practitioner and the condition of the patient. Since the overall patient population at CVAMC tends to be psychotic, or regressed, or chronic, or a total care patient, the performance of simultaneous interventions is often times difficult.

Many of the interventions as defined such as participating with the patient in recreational or diversional activities may appear to be in the province of another service. The point is well taken, however; in a neuropsychiatric facility, patients, especially because they are psychotic, regressed, etc. need the type and amount of patience, care, supervision and reinforcement that services such as Recreation cannot totally provide. In this instance nursing and the other service must work in a collaborative manner. It is also important for nursing personnel to observe the patient away from the unit setting. Much valuable information about the patient can be gained through this participative and observational function.

Another consideration the reader of this proposal may have concerns itself with what an additional 813.1 FTE would do to the Core Staffing Ratio at CVAMC. The Core Staffing Ratio for FY 1982 at CVAMC was 1.47 based on an ADPC of 904.7. The Core Staffing Ratio is calculated based on the guidelines set forth in VA Circular 10-79-259, dated November 5, 1979. Implementation of this proposal, using an ADPC of 904.7 would increase the Core Staffing Ratio at CVAMC to 2.24; an increase of 0.77. Utilizing this proposal's projected ADPC and operating beds of 950, the Core Staffing Ratio at CVAMC would increase to 2.13; an increase of 0.66. Considering the complexity of services required by the psychiatric patient, who in many instances also has medical problems, this increase does not appear to be exhorbitant. Historically GM&S facilities have had higher Core Staffing Ratios than neuropsychiatric

facilities. The care required by the psychiatric patient is not any less demanding or complex in comparison to the patient in a GM&S facility; it is merely provided from a different perspective. In addition C.V.A.M.C. has become affiliated with Thomas Jefferson University. The assumption that provision of better patient care through medical school affiliation will occur through the implementation of new programs is an accepted premise. New and expanded programs generally require more staff.

The submission of this proposal for an additional 813.1 FTE in Nursing is a large request. For that reason, no calculation was included to cover the non-productive time of the additional 813.1 personnel requested. Within the private sector this figure is usually around 15%.

Nursing service at C.V.A.M.C. realizes that it is obligated to provide safe care to the veteran population and has been forced to use overtime in situations where patient care could be unsafe because of lack of staff. During the 1983 Fiscal Year Nursing Service authorized approximately $223,000.00 in overtime. This amount was approximately $45,000.00 over what was authorized in Fiscal Year 1982. The average RN salary at C.V.A.M.C. is $29,024.00, the average LPN/NA salary is $17,710.00. This computes to 7.7 FTE RN's or 12.6 LPN/NA that were needed to provide "bare" coverage. There is no reason to believe that overtime will not continue to escalate to provide that "bare" coverage. The question is "Is this use of overtime the best way to allocate resources?" Clearly the answer is no; individualized treatment of the veteran patient cannot occur with this system.

THE ACUTE PSYCHIATRIC PATIENT

The Acute Psychiatric Patient may be in the age range of 22 to 70 years. The patient has had previous multiple psychiatric admissions and frequently has a history of past suicidal attempts and/or acting out behavior. The patient is typically irritable and angry. Self destructive behavior may be demonstrated. Drug and alcohol dependency is common. The patient is most often not in touch with reality; hallucinations and delusional thinking are commonplace. Personal hygiene is generally lacking and the nutritional status of the patient is poor. External and family support systems are minimal.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Crisis intervention and providing a safe environment to protect the patient from self harm or harming others. Included is constant observation when it is necessary to place the patient in seclusion or restraints.	1.12	1.50	1.88
2. Developing and maintaining a therapeutic relationship with the patient to give support and encourage the patient to verbalize fears, feelings, and anxieties.	1.50	2.00	2.50
3. Monitoring and ensuring that the patient ingests adequate amounts of food and fluids at mealtime. This may include actually sitting with the patient at mealtime to encourage eating and in some instances feeding the patient.	0.19	0.25	0.31
4. Assisting the patient in performing activities of daily living including dressing and grooming.	0.56	0.75	0.94
5. Monitoring the sleeping patterns of the patient and taking appropriate actions such as talking to the patient or giving the appropriate sleep medication when the patient is unable to sleep.	0.56	0.75	0.94

		NHPD	
	Minimal	Midpoint	Optimal
6. Orienting the patient to reality. This includes consistently reminding the patient who he is and where he is.	0.75	1.00	1.25
7. Re-directing the patient's thoughts when hallucinations or delusional thinking are demonstrated.	0.75	1.00	1.25
8. Assisting and encouraging the patient to participate in therapeutic activities such as playing pool and swimming. Included is the actual escorting of the patient to the activity.	0.56	0.75	0.94
9. Administering medications to the patient and assessing the therapeutic and possible side effects of the medication.	0.56	0.75	0.94
10. Educating the patient regarding the psychiatric illness, substance abuse dependency problem, associated treatments, and medications.	0.37	0.50	0.63
11. Administrative time required to process admissions, make rounds with physicians, initiate physicians orders, document on the clinical record, participate in patient care planning meetings, and coordinate unit functioning with the associated administrative requirements.	0.75	1.00	1.25
TOTALS	7.67	10.25	12.83

A.D.P.C. of Prototype Patients at CVAMC = 150
Number of Nursing Hours required for all patients/day = 1537.5
Number of Nursing Hours required for all patients/week = 10762.5
Number of Nursing FTE required = 269

THE INTERMEDIATE PSYCHIATRIC PATIENT

The Intermediate Psychiatric Patient can be in the age range of 22-70 years but most commonly is in the middle age group. Schizophrenia, Paranoid Type is the most frequent psychiatric diagnosis. Often this patient has a secondary diagnosis of alcohol, drug, or combined alcohol/drug dependence. This patient is in the sub-acute phase of the illness and is still prone to relapses. Previous hospitalizations have been frequent for varying lengths of time. This re-admission tendency is fostered by a poor support system and lack of vocational skills. The patient is usually delusional, has hallucinations and exhibits poor impulse control. Acting out behavior is common and often related to the ingestion of alcohol and/or drugs. The patient is uninterested or incapable of performing basic activities of daily living and therefore is institution dependent. Close observation and supervision of this patient is required. Discharge planning is difficult because of the multiplicity of problems and the use of outpatient treatment facilities is sporadic between hospitalizations.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Encouraging the patient to participate in therapeutic activities. Included is the actual escorting of patients on off-station trips or participating with the patient in activities such as swimming.	1.12	1.50	1.88
2. Assisting and encouraging the patient to perform activities of daily living stressing the development of good grooming, bathing and dressing habits.	0.75	1.00	1.25
3. Developing a therapeutic relationship with the patient. The following issues are addressed during the interaction:			
A. Verbalization of feelings, fears and anxieties.			
B. Problem identification and resolution.	0.75	1.00	1.25
C. Discussion and identification of feelings, thoughts, etc. that initiate the ingestion of alcohol, drugs, or both.			

	Minimal	NHPD Midpoint	Optimal
D. Planning for discharge and reinforcement of the importance of utilizing outpatient facilities on a consistent basis.			
4. Managing the patient during periods when agitated behavior or delusional thinking are demonstrated. This may be related to the ingestion of alcohol, drugs or both. Specific interventions may include removing the patient to a quiet area, talking to the patient and/or administering medication.	0.75	1.00	1.25
5. Administering medications and assessing the therapeutic and possible side effects of the medications.	0.37	0.50	0.63
6. Educating the patient regarding the psychiatric illness, dependency problem, treatments and medication.	0.37	0.50	0.63
7. Assessing daily the mental status of the patient to determine the need for care plan revision.	0.19	0.25	0.31
8. Teaching the patient those basic skills such as bedmaking and cooking which will be utilized when discharged.	0.19	0.25	0.31
9. Administrative time required to make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.11	0.15	0.19
TOTALS	4.60	6.15	7.70

A.D.P.C. of Prototype Patients at CVAMC = 170
Number of Nursing Hours required for all patients/day = 1045.5
Number of Nursing Hours required for all patients/week = 7318.5
Number of Nursing FTE required = 183

THE CHRONIC PSYCHIATRIC PATIENT

The Chronic Psychiatric Patient is in middle or later life and most commonly has a psychiatric diagnosis of Schizophrenia, Undifferentiated Type. Mood swings are typical of this patient ranging from withdrawal to hyperactivity. Delusional thinking and acting out behavior are frequently demonstrated. The patient may be disoriented as to time, place and person and demonstrate symptomotology of an Organic Brain Syndrome. Personal hygiene habits tend to be lacking. The nutritional status of the patient is poor; often there is hoarding of food. The patient manifests signs and symptoms of medical diseases such as Diabetes Mellitus and Chronic Obstructive Pulmonary Disease. Multiple medications are often required to manage both the psychiatric and medical conditions, with poor patient compliance. Support systems and positive interpersonal relationships are often non-existent. Community outplacement is difficult.

Nursing interventions for this patient: include:

	NHPD		
	Minimal	Midpoint	Optim
1. Monitoring the patient's weight and ensuring the patient ingests adequate amounts of food and fluids to maintain proper body weight. This may require actually feeding the patient.	1.69	2.25	2.81
2. Assisting the patient with total grooming and dressing.	1.50	2.00	2.50
3. Daily outing with the patient or participation in a therapeutic activity, such as swimming, to re-channel energy. This also includes escorting the patient to the activity.	0.75	1.00	1.25
4. Frequent interaction with the patient to encourage the patient to verbalize feelings, thoughts, and needs.	0.75	1.00	1.25
5. Orienting the patient to reality frequently during the day. This may also include inclusion of the patient in a Reality Orientation Program.	0.37	0.50	0.63

		NHPD	
	Minimal	Midpoint	Optimal
6. Intervening when the patient is withdrawn or hyperactive to prevent self or other directed destuctive bahavior. This may include removing the patient from the environment to an area where the patient can be closely observed and attended to.	0.37	0.50	0.63
7. Providing a safe environment that protects the patient from injury from the physical surroundings and other agitated patients. Included is the removal of physical safety hazards and the therapeutic management of other agitated patients who have a potential for striking out.	0.37	0.50	0.63
8. Administering medications to the patient and assessing the therapeutic and possible side effects of the medications.	0.37	0.50	0.63
9. Daily assessment of the patient's mental and physical status to determine the need for care plan revision.	0.19	0.25	0.31
10. Educating the patient regarding the psychiatric and medical illness, associated treatments and medications.	0.19	0.25	0.31
11. Administrative time required to make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.11	0.15	0.19
TOTALS	6.66	8.90	11.14

A.D.P.C. of Prototype Patients at CVAMC = 132
Number of Nursing Hours required for all patients/day = 1174.8
Number of Nursing Hours required for all patients/week = 8223.6
Number of Nursing FTE required = 205.6

THE SUBSTANCE ABUSE DETOXIFYING PATIENT

The Substance Abuse Detoxifying Patient is generally in the age range of 20 to 70 years and may have an alcohol, drug, or combined alcohol/drug dependence problem. The patient may be a voluntary admission or court stipulated; legal problems are common. Many of the patients also have a psychiatric diagnosis or a personality disorder. The medical problems associated with substance abuse are common and include cirrhosis, peripheral neuropathy, absesses, etc. Typically, the detoxifying patient demonstrates denial of addiction, poor self-esteem and mood swings. Depressive symptomatology, often with previous suicidal attempts is common. Positive interpersonal relationships are lacking in addition to poor social and coping skills. Manipulative and demanding behavior is common; which can lead to acting out behavior. Nutritionally, their status is poor. External support systems are limited.

Nursing Interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Close supervision and monitoring of the physical and emotional status of the patient. This includes assessment of behaviors or signs and symptoms indicative of withdrawal.	2.25	3.00	3.75
2. Providing emotional support to the patient when physical and psychological signs of withdrawal occur. Included is dealing with the associated irritable, frightened or demanding behavior of the patient and limit setting.	1.50	2.00	2.50
3. Frequent interaction with the patient:			
A. To assist the patient in identifying problems and resolutions.	0.75	1.00	1.25
B. To assist the patient to identify those interaction patterns or behaviors which impede the patient's progress.			

	NHPD		
	Minimal	Midpoint	Optimal
4. Crisis intervention when the potential for acting out behavior occurs. This may include physically removing the patient to a quiet area of the unit and "talking the patient down."	0.37	0.50	0.63
5. Monitoring and ensuring that the patient ingests adequate amounts of food and fluids.	0.37	0.50	0.63
6. Assisting and encouraging the patient as allowed to exercise or participate in diversional activities such as swimming to re-channel energy. This includes actual escorting of the patient to the activity.	0.37	0.50	0.63
7. Administering medications and assessing the therapeutic and possible side effects.	0.37	0.50	0.63
8. Educating the patient in regard to the detoxifying process and the ramifications of continued alcohol/drug dependence.	0.19	0.25	0.31
9. Administrative time required to process admissions, make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.75	1.00	1.25
TOTALS	6.92	9.25	11.58

A.D.P.C. of Prototype Patients at CVAMC = 20
Number of Nursing Hours required for all patients/day = 185
Number of Nursing Hours required for all patients/week = 1295
Number of Nursing FTE required = 32.4

THE SUBSTANCE ABUSE REHABILITATION PATIENT

The Substance Abuse Rehabilitation Patient is usually between the ages of 24 and 50 years. The patient has completed the detoxification process but still remains highly unstable both physically and psychologically. Typically, the patient is angry and lashes out at others especially if they are in authority positions. Acting out may occur since these patients have difficulty adjusting to constraints on their behavior and the expectations of the program. Problem solving and introspective abilities are lacking causing thoughts and emotions to become overwhelming. Patients are typically demanding yet may be depressed; impulse control is poor. Medical problems related to substance abuse dependency are common. Personal neglect is manifested by poor nutritional status. From an educational standpoint, these patients often lack a high school diploma and thus have few skills on which to base vocational planning; employment problems are rampant. A social support system is lacking.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Developing a therapeutic relationship with the patient and encouraging the patient to participate in group therapy. The following issues are addressed:			
A. Identifying problems and possible solutions.			
B. Identifying non-coping strategies such as denial which impede the patient in the rehabilitation process.	1.50	2.00	2.50
C. Dealing with anger and authority figures.			
D. The importance of the development of leisure time activities.			
2. Assessing daily the physical and psychological status of the patient for care plan revision.	0.37	0.50	0.63

	NHPD		
	Minimal	Midpoint	Optimal
3. Assisting the patient in redirecting anger through the use of diversional activities, exercise, and group therapy.	0.37	0.50	0.63
4. Reinforcing the rules and regulations of the program and the expected behaviors of the patient which the patient has agreed to in the form of a contract. Included is dealing with the patient when manipulation or demanding behavior is demonstrated.	0.37	0.50	0.63
5. Educating the patient concerning the dependency problem, complications, nutrition, medications, and general and specific health problems.	0.37	0.50	0.63
6. Crisis intervention including "talking the patient down" to prevent potential acting out behavior.	0.19	0.25	0.31
7. Ensuring and encouraging the patient ingests adequate amounts of food and fluids during meal time.	0.19	0.25	0.31
8. Administering medications and assessing the therapeutic and possible side effects.	0.11	0.15	0.19
9. Administrative time required to make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.11	0.15	0.19
TOTALS	3.58	4.80	6.02

A.D.P.C. of Prototype Patients at CVAMC = 90
Number of Nursing Hours required for all patients/day = 432
Number of Nursing Hours required for all patients/week = 3024
Number of Nursing FTE required = 75.6

THE POST TRAUMATIC STRESS DISORDER PATIENT

The Post Traumatic Stress Disorder Patient is young to middle age having served in the Viet Nam Conflict. The patient representative of this order has not, in many instances, been able to discuss the combat experience previously. These patients have pent up emotions of guilt, fear and feel alienated from society. Impulsive behavior is not uncommon. Flashbacks and nightmares dealing with the combat experience are common. Low self-esteem and poor interpersonal relationships contribute to their sense of worthlessness. Vocational skills were never developed since the transition from adolescence to adulthood was interrupted by military service. The use of abusing substances is common.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Developing a therapeutic relationship with the patient and encouraging the patient to participate in group therapy during which the following issues are addressed:			
A. Allowing the patient to verbalize the thoughts and feelings related to the combat experience in a non-threatening secure environment.			
B. Allowing the patient to verbalize current thoughts and feelings.	2.62	3.50	4.38
C. Identification of problems with possible solutions.			
D. Identification of strengths to promote self concept.			
E. Goal setting.			
2. Crisis intervention including "talking the patient down" when there is a potential for acting out behavior.	0.56	0.75	0.94
3. Assisting the patient in redirecting the impulsive and angry behavior through diversional activities and exercise.	0.37	0.50	0.63

	NHPD		
	Minimal	Midpoint	Optimal
4. Monitoring sleeping patterns and taking appropriate actions such as reassuring the patient and/or giving prescribed sleep medications.	0.37	0.50	0.63
5. Educating the patient about the dependency problems, complications, medications and the importance of maintaining good general health status.	0.37	0.50	0.63
6. Administering medications and monitoring the therapeutic and possible side effects.	0.37	0.50	0.63
7. Re-enforcing the rules, regulations and expectations of the program which the patient agreed to upon admission. Included is dealing with manipulative and/or threatening behavior and limit setting.	0.19	0.25	0.31
8. Encouraging and assisting the patient to develop better interpersonal skills through participation in unit activities such as patient government and unit projects.	0.11	0.15	0.19
9. Administrative time required to make rounds with physicians, initiate orders, participating in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.26	0.35	0.44
TOTALS	5.22	7.00	8.78

A.D.P.C. of Prototype Patients at CVAMC = 13
Number of Nursing Hours required for all patients/day = 91
Number of Nursing Hours required for all patients/week = 637
Number of Nursing FTE required = 16

THE PRE OUTPLACEMENT PATIENT

The Pre Outplacement Patient is preparing to re-enter the community or enter a domicilliary after hospital discharge. The patient can be any age. Schizophrenia either Paranoid or Undifferentiated Type or a substance abuse dependency problem are the most common diagnoses. This patient typically has a history of multiple hospital re-admissions and demonstrates severe social disability. Behaviorally the patient is manipulative and aggressive or depressed and passive. In addition, this patient is anxious, institution dependent and has difficulty with authority figures. Vocational skills and goal orientation are lacking. This patient lacks a social support system. In most instances, the patient is ambulatory but may evidence residual effects of chronic medical conditions such as difficulty in breathing. Personal hygiene habits tend to be poor thus comprising the capacity for independent living.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Developing a therapeutic relationship with the patient. The following issues are addressed:			
A. Reality testing: "what is" versus the patient's perception of "what is."			
B. Identifying feelings and thoughts and how these may interfere with functioning.			
C. Identifying problems and possible solutions.	1.31	1.75	2.19
D. Dependent/independent functioning			
E. Providing feedback regarding the patient's style of interaction in dealing with everyday problems.			
2. Educating the patient in regard to specific topics which include:			
A. Medications, therapeutic and possible side effects.			

	Minimal	NHPD Midpoint	Optimal
B. Dealing with the chronic disease.			
C. Re-enforcement of the importance of complying with treatment regimes.			
D. The ramifications of ingesting alcohol, drugs or both.	0.19	0.25	0.31
E. Developing skills in activities of daily living.			
F. Use of leisure time and healthy recreation.			
G. Developing appropriate coping skills to deal with stress and problems.			
3. Monitoring the patient's personal hygiene habits.	0.11	0.15	0.19
4. Setting limits and re-enforcing the program expectations.	0.19	0.25	0.31
5. Monitoring the patient's compliance in taking self medications.	0.15	0.20	0.25
6. Administrative time required to make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.22	0.30	0.38
TOTALS	2.17	2.90	3.63

A.D.P.C. of Prototype Patients at CVAMC = 49
Number of Nursing Hours required for all patients/day = 142.1
Number of Nursing Hours required for all patients/week = 994.7
Number of Nursing FTE required = 24.9

THE ACUTE MEDICAL PATIENT

The Acute Medical Patient can be any age but typically is in the middle to later years. The patient manifests life threatening conditions which necessitate immediate treatment. These conditions are most often related to the cardiac and respiratory systems and frequently co-exist with a psychiatric diagnosis. Management of the emergent medical condition is complex especially when complications such as renal failure occur. Constant physical and mental assessment of the patient and the monitoring of life sustaining equipment are mandatory. Highly sophisticated and often times emergency procedures are performed requiring a high degree of technical skill. Throughout the process the dignity of the patient must be maintained. Total care of the patient is required.

Nursing Interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Basic care which includes bathing, feeding and toileting.	3.00	4.00	5.00
2. Monitoring the patient who is on a cardiac monitor or is dependent on equipment such as a ventilator.	3.00	4.00	5.00
3. Performing procedures such as suctioning, drawing blood and catheter care.	1.50	2.00	2.50
4. Administering medications, intravenous therapy and assessing the therapeutic and possible side effects.	1.50	2.00	2.50
5. Complete physical assessment of the patient on each tour of duty for the purpose of care plan revision.	1.50	2.00	2.50
6. Providing psychological support and education to the patient and family during the crises.	1.50	2.00	2.50
7. Administrative time required to process admissions, make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.75	1.00	1.25
TOTALS	12.75	17.00	21.25

Number of Projected Operating Prototype Patient beds at CVAMC = 5
Number of Nursing Hours required for all patients/day = 85
Number of Nursing Hours required for all patients/week = 595
Number of Nursing FTE required = 14.8

THE MEDICAL PATIENT

The Medical Patient may be a middle aged or later life psychiatric patient with a superceding chronic illness(es) such as Chronic Obstructive Pulmonary Disease or Diabetes Mellitus that is in exacerbation. The patient is acute but does not require life sustaining measures such as mechanical respiratory support. Almost total care is required for this patient including assistance in activities of daily living and close observation. Nutritional status is often maintained through the use of tube feedings. Intravenous infusions, oxygen therapy and complex treatments are often necessary. Skin breakdown and pneumonia are examples of potential problems for this patient. The patient may be disoriented and demonstrate psychiatric symptomatology requiring close behavioral monitoring and reorientation.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Providing care which includes bathing, toileting, feeding and ambulating.	2.25	3.00	3.75
2. Close observation and performing such procedures as turning the patient every two hours and catheter care.	2.25	3.00	3.75
3. Monitoring and ensuring the patient ingests adequate amounts of food and fluids. This includes monitoring of intravenous therapy, in some instances feeding the patient or administering tube feedings on a frequent basis.	1.12	1.50	1.88
4. Providing psychological support to the patient and family.	0.75	1.00	1.25
5. Administering medications and intravenous therapy.	0.37	0.50	0.63
6. Assessing the therapeutic value and possible side effects of medications and treatments.	0.37	0.50	0.63
7. Educating the patient with regard to the illness and medications.	0.37	0.50	0.63

		NHPD	
	Minimal	Midpoint	Optimal
8. Administrative time required to make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.37	0.50	0.63
TOTALS	7.85	10.50	13.15

Number of Projected Operating Prototype Patient beds at CVAMC = 71
Number of Nursing Hours required for all patients/day = 745.5
Number of Nursing Hours required for all patients/week = 5218.5
Number of Nursing FTE required = 130.5

THE GERIATRIC PATIENT

The Geriatric Patient is 60 years of age or older. The patient has a psychiatric diagnosis and has been associated with the hospital for a long period of time or has been admitted to the hospital with multiple physical problems which impair the ability to live independently. The patient may demonstrate signs and symptoms of an Organic Brain Syndrome. These patients typically have problems with mobility and have sensory deficits in hearing and vision. They are prone to accidents and fractures occur easily. Often their nutritional status is poor. Problems with bowel and bladder elimination are common. Ambulation is at a slower pace. Their sense of self worth is diminished and they may be disoriented as to time, place and person. Frustration is often exhibited by the patient in the form of combative or agitated behavior when they are unable to compensate for their declins in physical abilities. For those patients with aphasia or Parkinson's Disease, the ability to communicate is hampered. Family support is minimal due to lack of family members or illness of the significant other.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Interacting with the patient in an unhurried manner, encouraging the patient to interact with others, and assessing and re-planning care based on the patient's functional ability and tolerance.	1.50	2.00	2.50
2. Monitoring and ensuring that the patient ingests adequate amounts of food and fluids. This may include assistance at meals or actually feeding the patient.	1.12	1.50	1.88
3. Assisting the patient with activities of daily living including bathing, dressing and grooming.	0.75	1.00	1.25
4. Administering medications and assessing the therapeutic and possible side effects.	0.37	0.50	0.63
5. Providing an environment free from hazards by constant monitoring of the physical surroundings. Assessing the patient in regard to sensory deficits such as hearing and instituting appropriate measures to compensate for any deficit.	0.37	0.50	0.63

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	NHPD		
	Minimal	Midpoint	Optimal
6. Assisting and encouraging the patient to participate in recreational and physical therapies. Included is the actual escorting of the patient on off-station trips or to the assigned therapy sessions.	0.37	0.50	0.63
7. Assessing the patient both mentally and physically; this may necessitate placing the patient in a structured Reality Orientation Program or placing the patient on a bowel/bladder training program.	0.37	0.50	0.63
8. Administrative time required to make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record and coordinate unit functioning with the associated administrative requirement.	0.37	0.50	0.63
TOTALS	5.22	7.00	8.78

A.D.P.C. of Prototype Patients at CVAMC = 201
Number of Nursing Hours required for all patients/day - 1407
Number of Nursing Hours required for all patients/week = 9849
Number of Nursing FTE required = 246.2

Projected Operating Beds for new NHCU = 120
Number of Nursing Hours required for all patients/day = 840
Number of Nursing Hours required for all patients/week = 5880
Number of Nursing FTE required = 147

THE ALZHEIMER'S PATIENT

The Alzheimer's Patient is in the age range of 48 to 72 years and demonstrates symptomatology of late stage 2 or early stage 3 of the disease. This patient is usually well-educated and has an extensive family support system. Psychologically, the patient has profound memory loss, impairment of intellectual functioning and is disoriented as to time, place and person. Communication efforts by the patient are often illogical and incoherent. Functionally, the patient cannot perform the activities of daily living such as toileting, bathing, feeding and grooming. Patients are most often incontinent. Because of the physical decline and the associated inability to function independently, the patient typically becomes frustrated and is often irritable and resistive to care givers. Hightened physical activity is periodically demonstrated. Seizures are not uncommon in this patient. This total care patient requires close observation and supervision.

Nursing Interventions for this patient include:

	NMPD		
	Minimal	Midpoint	Optimal
1. Assisting the patient with bathing, feeding, and grooming.	1.31	1.75	2.19
2. Assisting the patient at mealtime. This may include feeding the patient or assisting the patient in manipulating the spoon or fork.	1.12	1.50	1.88
3. Monitoring and providing a safe and predictable environment by continuously supervising the patient on the unit while ambulatory or performing activities. Escorting the patient to activities and appointments is required.	0.75	1.00	1.25
4. Monitoring the patient's incontinence: changing incontinence pants every 2-3 hours, assisting the patient to the bathroom, or initiating a bowel/bladder training program.	0.75	1.00	1.25
5. Interacting with the patient in an unhurried manner to provide psychological support and reality orientation. Included is intervening when the patient becomes hyperactive.	0.56	0.75	0.94

		NHPD	
	Minimal	Midpoint	Optimal
6. Assessing the physical capabilities of the patient daily for care plan revision.	0.37	0.50	0.63
7. Administering medications and assessing the therapeutic value and/or possible side effects.	0.37	0.50	0.63
8. Administrative time required to make rounds with physicians, initiate orders, document on the clinical record, participate in patient care planning meetings and coordinate unit functioning with the associated administrative requirements.	0.22	0.30	0.38
TOTALS	5.45	7.30	9.15

A.D.P.C. of Prototype Patient at CVAMC = 20
Number of Nursing Hours required for all patients/day = 146
Number of Nursing Hours required for all patients/week = 1022
Number of Nursing FTE required = 25.6

THE CHRONIC NEUROLOGICAL PATIENT

The Chronic Neurological Patient is in the age range of 35 to 70 years and commonly has a diagnosis of Parkinson's Disease, Multiple Sclerosis, Huntington's Chorea or is a post head trauma victim. Because of the incurred brain damage or the disease process itself, the patient demonstrates an impairment of perception and intellectual and motor functioning. The patient may be fully alert or unconscious. The deteriorating physical condition and the psychological changes associated with the disease process itself causes frustration on the part of the patient. Functionally, the patient is unable to perform self care activities such as bathing, feeding, grooming and toileting; thus is dependent on others to meet these needs.

Nursing interventions for this patient include:

	NHPD		
	Minimal	Midpoint	Optimal
1. Providing basic care which includes bathing, oral hygiene, assisting with toileting, and range of motion exercises.	2.25	3.00	3.75
2. Insuring the patient ingests adequate amounts of food and fluids. This may include feeding the patient or administering tube feedings.	1.50	2.00	2.50
3. Close observation and performing procedures such as suctioning, positioning, and catheter care.	0.75	1.00	1.25
4. Providing psychological support to the patient through frequent and unhurried patient interactions.	0.75	1.00	1.25
5. Administering medications and intravenous therapy. Assessing the therapeutic value and possible side effects of medication.	0.37	0.50	0.63
6. Assessing the patient neurologically and revising care as needed.	0.37	0.50	0.63
7. Educating the patient in regard to the illness, medications and treatments.	0.37	0.50	0.63

	NHPD		
	Minimal	Midpoint	Optimal
8. Administrative time required to make rounds with physicians, initiate orders, participate in patient care planning meetings, document on the clinical record, and coordinate unit functioning with the associated administrative requirements.	0.11	0.15	0.19
TOTALS	6.47	8.65	10.83

A.D.P.C. of Prototype Patients at CVAMC = 29
Number of Nursing Hours required for all patients/day = 250.9
Number of Nursing Hours required for all patients/week = 1755.9
Number of Nursing FTE required = 43.9

THE AMBULATORY CARE PATIENT

The Ambulatory Care Patient is in the age range of 19 to 88 years and may be an outpatient, inpatient, service connected or non-service connected veteran. In addition, employees of the facility are monitored yearly and may be treated under certain conditions. The patient may be treated in one or more of the following areas: 1. Mental Hygiene Clinic; 2. Ambulatory Care including the 14 clinics; 3. Admissions or 4. Employee Health. The patient may have a psychiatric diagnosis, substance abuse dependency problem, acute or chronic medical diseases, or an on-the-job injury in the case of employees. The total number of visits for the year ending September, 1982, was 33,656. The greatest number of patient visits are during the administrative work week; approximately 125 per day.

Nursing interventions for this patient include:

		NHPD	
	Minimal	Midpoint	Optimal
1. Assessing the patient medically and/or psychologically.	0.37	0.50	0.63
2. Coordinating the movement of the patients within the clinics or to other VA facilities.	0.19	0.25	0.31
3. Educating the patient in regard to the disease entity, therapy and medication.	0.19	0.25	0.31
4. Escorting the patient to the unit or to other VA facilities for treatments, procedures, or follow up care.	0.11	0.15	0.19
5. Employee counseling	0.07	0.10	0.13
6. Initial assessment of all admissions	0.07	0.10	0.13
7. Administrative time including documentation on the clinical record and clinic coordination with the associated administrative requirements.	0.07	0.10	0.13
TOTALS	1.07	1.50	1.83

Number of Prototype Patients/day at CVAMC = 125
Number of Nursing Hours required for all patients/day = 187.5
Number of Nursing Hours required for all patients/week = 937.5
Number of Nursing FTE required = 23.4

APPENDIX I

"SUBSTANTIATING PATIENT DATA"

During the month of March 1983, there were 114 Patient incidents reported at CVAMC. Of the 114 reported incidents, there were 64 reported patient to patient assaults. During June 1983, one registered nurse and three nursing assistants were assaulted by patients. The trend of patient and employee assaults has necessitated the implementation of a Psychiatric Emergency Assistance Team at CVAMC which is composed of nursing personnel who are specially trained to manage the potential or acting out patient. Controlling mechanisms such as seclusion or leather restraints have also been necessary. During March 1983, seclusion or leather restraints had to be utilized a total of 41 times. Seclusion was utilized a total of 56 hours; restraints a total of 137 hours and 10 minutes. Total use for both was 193 hours and 10 minutes or 26% of the total number of hours for the month.

Thirty five patient falls were reported for the month of May 1983; 20 of these falls occurred on the medical and geriatric areas. This computes to 57% of the falls occurring in these areas.

Therefore, nursing personnel appear to spend what time they have in managing crisis situations, not planning or implementing or supervising patient care.

APPENDIX II

"EXPLANATION OF TERMS & CALCULATIONS"

For the purpose of this proposal the following terms are defined:

1. Prototype Patient - That patient who most typically represents a group of veterans receiving care at CVAMC.

2. Nursing Interventions - Those specific nursing actions undertaken to resolve an identified patient problem or need.

The calculations of the nursing FTE requirement for each prototype patient at CVAMC was determined by utilizing the Nursing Hour Per Patient Day (NHPD) which is equivalent to 60 minutes. Each intervention was timed as a multiple or proportion of a nursing hour i.e. 2.0 NHPD = 120 minutes, 0.25 NHPD = 15 minutes. Three different times in terms of NHPD were assigned to each intervention; the minimal amount of time required to perform the intervention, the optimum amount of time required to perform the intervention and a midpoint time. The total NHPD for the prototype patient was obtained by summing the allocated times for the interventions. The Average Daily Patient Census (A.D.P.C.) for each prototype patient was determined and utilized in conjunction with the total midpoint NHPD to compute the required nursing FTE.

CONCLUSION

Quality individualized nursing care cannot be provided at Coatesville Veterans Administration Medical Center with the current nursing ceiling.

This proposal as submitted not only has implications for the quality of nursing care that could be potentially delivered at CVAMC but also on a system wide basis. The Veterans Administration as part of the total health care delivery system has many times served as the role model in the clinical, administrative, research and educational areas. From a clinical perspective, the delivery of individualized care has historically been given increasing emphasis from such standard formulating and accrediting bodies as the Joint Commission on Accreditation of Hospitals. Patient rights, patient privacy and hospital responsibility continue to be vital issues. Although such health care legislation as T.E.F.R.A. and the implementation of prospective reimbursement schemes such as D.R.G.'s add the element of fiscal responsibility, the health care professions and particularly the nursing profession in its role as patient advocate must address the quality and quantity of care provided not only in terms of what the patient deserves but also in terms of the responsibility the health care facility assumes in providing that care. This proposal is in fact a first step in defining the many prototype patients found in a hospital identified as neuropsychiatric facility and the nursing care required.

Nursing of course does not provide services within a vacuum. It must collaborate with others within the multidisciplinary setting, most notable are the collaborative efforts required between nurses and physicians. A physician shortage at CVAMC is evident and as such the collaborative efforts needed for the delivery of quality patient care are lacking.

Implementation of this proposal with the subsequent increased nursing ceiling ensures from a nursing perspective that quality individualized nursing care can be delivered.

Thank you for your consideration in this matter.

STATEMENT OF
GORDON H. MANSFIELD, ASSOCIATE EXECUTIVE DIRECTOR
FOR GOVERNMENT RELATIONS
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOSPITALS AND HEALTH CARE SUBCOMMITTEE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
THE ADEQUACY OF VA HEALTH CARE RESOURCES
SEPTEMBER 7, 1988

Mr. Chairman, Paralyzed Veterans of America appreciates this opportunity to present our views on the status of the Veterans Administration's (VA) health care resources and the ability of the VA to maintain the quality and quantity of care veterans of this nation require.

Mr. Chairman, in our opinion the VA health care system is in deep trouble. Years of budget shortfalls have cut into the bone of the system's ability to maintain bed levels, staffing levels, and timeliness in the provision of essential medical services.

Veterans are being denied access to quality health care.

Medical services are being rationed based on the availability of resources - medical equipment, supplies, pharmaceutical and prosthetics.

The VA cannot continue to meet the increasing needs of older and disabled veterans unless significant resources are applied to meet obligated service levels mandated by the Congress.

From a fiscal standpoint, the average VA medical center is eating itself alive. It is cannibalizing existing resources for building maintenance, repair, modern medical equipment, essential medical services and restricting and denying access to medical care for eligible veterans in order to meet yearly major deficits in operating funds.

VA Administrator Thomas Turnage appeared before PVA's Annual Convention in Chicago, Illinois, on August 24, 1988. He stated the following:

> (This Administration) has done more, contrary to what critics say, to improve and enhance veterans' benefits and services than any Administration since the last soldiers returned home from the Second World War. Even in today's environment of bipartisan efforts to cut federal spending, VA's budget, workforce and physical plant are all larger than they have ever been . . . He went on to say, "In spite of all that's been accomplished, there are still those who want to criticize. Their answer to all of the alleged shortages is always more money, more resources."

Mr. Chairman, I believe it safe to say that VA budgets over the past eight years would have been an utter disaster if the Congress, in a bipartisan effort, hadn't bailed the VA out by restoring certain funds to yearly proposed Administration budgets. Over the years, OMB has shown no interest, concern or respect for the needs of the VA medical system. Their budget analysts have deliberately set the VA adrift. We must make certain that the system is set back on course.

Over the past several years, the Administrator, as well, has demonstrated either a careless disregard for the facts or a total unwillingness to accept the truth from his own subordinates as to the ability of the VA to perform its mandated mission. If you look at the ledger sheets, it sure sounds good to say that VA budgets have increased since 1945 - they sure have - but so

have the complexity and expense of modern medicine and the increasing needs of aging and disabled veterans.

Even with the funds restored by Congress over the past several years, the VA health care system is strapped. Thousands of useable hospital beds have been taken out of service due to the lack of nurses and support staff. Eligible veteran patients are being denied care. Surgery, medical treatment, prescriptions, and prosthetics are being rationed and delayed in a desperate attempt by medical center directors to overcome operating shortfalls that, in many instances, run into 7 figures each year.

A sign which appeared last month at the San Diego, California, VAMC outpatient clinic is a clear example of what the present and future hold for the VA.

> ATTENTION: EFFECTIVE MONDAY, AUGUST 15, 1988, PATIENTS REQUIRING URGENT OR UNSCHEDULED CARE WILL NOT BE SEEN AT THIS FACILITY. THOSE PATIENTS SHOULD REPORT TO THE ADMISSION/TRIAGE AREA AT THE VETERANS ADMINISTRATION MEDICAL CENTER, 3350 LA JOLLA VILLAGE DRIVE. (Attachment A)

Administrator Turnage was quoted in The Washington Post on August 31, 1988, saying:

> We may not get what we want, but we get all we need to do our job well. Anyone who tells you we're not well-funded - well - I think they are whistling 'Dixie.'

Well, listen to what no less authority than the Administrator's own Chief Medical Director, Dr. John Gronvall, had to say about the adequacy of VA health care resources during hearings held by the Senate Veterans' Affairs Committee on July 14, 1988.

> I have just had a chance to review the past 10 years of data about the whole VA health care system. Without getting into too much detail, during that time, if you adjust our appropriation on the basis of medical care CPI, our funding has been level. During that time, we have significantly expanded the number of patients treated in our hospitals. We have significantly expanded the number of patients that we pay for in other hospitals. We have opened new nursing homes and significantly increased nursing home census - and we have amazingly expanded the extent of outpatient care going from 5 million visits a year to 20 million visits a year. All of that has been accomplished with an appropriation that is level in terms of purchasing power. That has been done by a whole set, I think, of very strong internal dynamics that put pressure on increased productivity and the accomplishment of new programs without real resources - and that has come about by reallocation from existing or previously existing programs ... All the information we have about the coming year, 1989, is even more bleak than the past ten years.

Mr. Chairman, that tune does not sound like "Dixie" to me. This statement sounds to me like a cry for help from a health care system in serious financial straights. This is the same cry for help that we have documented from an informal survey of VA medical centers conducted by PVA's National Service Officers over the past three weeks. The data obtained in this survey which we will present to this Committee separately paints a picture of a health care system which is being financially strangled. Quite frankly, Mr. Chairman, it is astounding that, for whatever reason, the VA Administrator is not willing, or able, to understand what his own medical managers are experiencing in the field and in Washington.

Part of this problem could come too from a situation where management in the VA has become so decentralized that individual VAMC's have been set adrift and have become far too removed from proper central office administration and oversight. Some of this decentralization is due to intentional administrative reorganization, but a great deal of it is due to lack of resources as well.

At the same Senate hearing on July 14, 1988, Dr. Gronvall was asked about the Department of Medicine and Surgery's efforts to monitor adequate quality assurance standards and review on-going in-patient treatment programs for Vietnam veterans at several VAMC's. His response was directed to the

existing inadequacy of current VA Central Office programs as a whole designed to monitor health care quality assurance system-wide.

"In the whole range of other review activities, where in the past we have made commitments for some schedule of Central Office review of programs, we have found that those commitments have been impossible to keep. The Central Office appropriation, in the past couple of years, has been cut back about 25 percent. So, we have had a reduction in staff, and in travel and support.

Again, as recently as August 24, Dr. Gronvall and his staff met with PVA representatives and representatives of other veterans' services organizations here in Washington. He told us then, quite simply, using his own words:

"DM&S has serious budget problems."

Dr. Gronvall also outlined a series of proposals which have been recommended to him by his staff which he hopes to implement October 1, 1988, in order to meet budget shortfalls. These measures include:

1. DM&S will not take funds off the top of the FY'89 appropriation to fund new initiatives.
2. Will defer programs to fund the acquisition of new high tech equipment.
3. Will defer program to purchase "joint venture" equipment, i.e., equipment purchased jointly with affiliated medical schools.
4. Eliminate contract support for organ transplants -- will be done in-house and will be limited to Category A patients.
5. Establish a system of controlling quantity of medical care in order not to compromise quality of care. Eligibility will be defined by statute. There will be equity of access to services on geographical basis.
6. Decentralize management of non-VA accounts - local VAMC's will control.
7. Freeze nonrecurring maintenance funds.
8. Terminate program of over-the-counter (OTC) drugs when veteran (discretionary) is being seen on outpatient basis only. Terminate prescription drugs for discretionary veterans (Category C). In this case, the VA would write the prescription and veteran would pay VA or take prescription to outside pharmacist.
9. Do not fully implement some of the discretionary provisions of P.L. 100-322, i.e., beneficiary travel. It will cost $50 million to fully expand beneficiary travel. FY'89 appropriations do not cover this. Other services would have to suffer if fully implemented. Ambulance travel, special mode transportation, and volunteer services would be sufficient to accommodate beneficiary travel.

Mr. Chairman all of these proposals will have a most serious effect on veteran patients in need of health care service. But one specific example comes to mind to bring this situation down to terms of basic human need. The Chief Medical Director stated that the availability of over-the-counter drugs and prescriptions and medical supplies would have to be curtailed for certain veterans.

For many catastrophically disabled veterans this would have disastrous consequences for their daily health maintenance. Included on the list of such over-the-counter items are bed-side drainage bags, gauze sponges, urinary pouches, rubber gloves, suppositories, paper tape, equipment and supplies for personal daily hygiene. Certain VAMCs are already refusing to provide these items. Attached is a memorandum from the Denver VAMC detailing restricted over-the-counter items at that facility. (Attachment B)

This is, Mr. Chairman, not the only example of how a shortage of funds for pharmaceuticals and staff VA pharmacists are causing cutbacks and disruptions in services, even for service-connected disabled veterans. PVA National Service Officer in Detroit, Michigan reports:

> About a year ago, the Ann Arbor VAMC announced a policy change whereby Pharmacies would no longer refill outpatient prescriptions. All refills would be processed through the Toledo, Ohio, Outpatient Clinic approximately 50 miles away. This policy change was necessary because of staffing shortages and high workload in Pharmacy Service.
>
> When I learned of this policy change, I met with the Chief of Pharmacy over the impact this change might have on the severely

disabled veteran. The Chief of Pharmacy informed me any emergency prescription would be refilled at the Pharmacy in Ann Arbor.

In March 1988, Ms. Judy Ross, who is service-connected for blindness, paraplegia and a seizure disorder secondary to MS, reported to the Outpatient Pharmacy to obtain medication for her seizure disorder. The Outpatient Pharmacy refused to refill the veteran's prescription and was told all refills are processed in Toledo.

As recently as June 1988 at the monthly service officers' meeting, I again expressed my concern regarding Pharmacy Service not filling emergency prescriptions at the window. To date (August '88) no reply has been received.

The PVA survey, designed for this testimony, received responses from over 100 of the VA's 172 medical facilities. Needless to say, considering internal VA organizational pressures, some medical centers were more forthright in commenting on their current condition than others. However, we would like to publicly express our appreciation to all of these medical center directors and their staff who cooperated so well with our request for information. They are on the front line of VA health care delivery serving veterans every day. We hope that this Committee would ensure that their candor in providing this information for the benefit of the Congress is fully protected. These men and women work very hard every day with what resources are made available to them, for the benefit of our nation's veterans. We are very grateful for their help and support.

To begin, Mr. Chairman, PVA understands that a Task Force has been appointed by the Chief Medical Director to review the Department of Medicine and Surgery's budget for the next fiscal year. The report predicts a Fiscal Year 1989 operating shortfall of well over $800 million. We believe this figure, while intolerable, to be a low estimate. Present projected shortfalls do not fully account for the decremental budgets passed on as "current services" figures. This eroded base-line has compounded the budget shortfall incrementally from one year to the next for the past eight years. Projected deficits do not even come close to addressing the actual needs of the system for research modern medical equipment and maintenance and repair funds.

Estimates contained in "The Independent Budget for the Veterans Administration" published earlier this year by four veterans' service organizations, including PVA, indicated that the system has up to a one billion dollar backlog in the purchase and acquisition of up-to-date medical equipment. Equipment and facility maintenance and modernization funds notoriously have been short changed in VA budget requests.

Historically, those funds are cannibalized to cover larger deficits in medical center operations and direct medical care. This activity has gone on uncontrollably for years in the VA. In the process, the agency has been "eating its own seed corn."

The inability of a medical center to maintain or replace equipment in accordance with new, albeit expensive, medical technology, presents both a direct threat to the quality of the health care provided and even higher costs when those services and procedures have to be contracted out to non-VA facilities. To cite just one example, we have been told that the fluoroscopy equipment at the West Haven, CT, VAMC was emitting, or leaking, uncontrollably high levels of radiation when in higher power use. No funds to replace the equipment were available at the time. As a temporary solution, the facility decided to fluoroscope only thin veterans at low power. Veterans with higher body weight were sent to the affiliated non-VA hospital for fluoroscopy to avoid the possibility of excess radiation exposure. Fortunately, this unit has been shut down entirely, but not replaced.

Mr. Chairman, as stated previously, we have presented the entire results of our survey to the Committee for your review. However, within the context of this testimony there are certain specific items we would like to present as examples which underscore the difficulties currently experienced in the VA health care system. From the start, this material makes clear that eligible veterans are being denied access to VA health care services.

- Attached for your review is a sample letter sent to a veteran from the Salem, Virginia, VAMC, denying care to that veteran

and stating that certain treatment is restricted only to service-connected disabled veterans. This would appear to be a complete abrogation of eligibility standards established in P.L. 99-272 and P.L. 100-322. (Attachment C)

- On April 7, 1988, the San Diego VA Medical Center Daily Bulletin advised its readers that .... "effective Monday, April 11, 1988, this Medical Center (to include the Mission Valley Outpatient Clinic) will begin to discontinue the provision of service to veterans in eligibility category C. This discontinuation of service is due to a decline in the availability of resources. Medical Administration Service (MAS) will be developing the implementation plan for the change, and they will be disseminating this information to the staff. It is important to remember during this process of curtailment that it is MAS who will make the eligibility determination and advise the veterans. All veterans will receive an evaluation to determine the urgency of medical care required; however, not all veterans will be entitled to the recommended future care. This will be a difficult time for all of us, but more importantly for those veterans who will be informed that they will not be able to receive care." (Attachment D)

- Letter of denial of care for Category C veterans at the San Diego, CA, VAMC. (Attachment E)

- On August 5, 1988, the Director of VAMC, Reno, NV, announced an approximately $2 million reduction in FY'89 funding for this medical facility. (Attachment F)

- On June 29, 1988, the Chief of Staff and Acting Director at Reno, NV, VAMC sent a letter to a local ambulance service requesting that the company " ... avoid bringing patients with SUSPECTED CARDIAC ISCHEMIA to the Reno VA Medical Center, effective immediately. This Medical Center has no staff cardiologist and is unable to provide prompt and appropriate care for such patients." (Attachment G)

- On April 18, 1988, VAMC Seattle was forced to limit access to several outpatient clinics to "new veterans with optional eligibility (priorities IV to X) in order to constrain workload within available funding." In addition, the medical center has twenty-six clinics which are closed to nonservice-connected veterans. (See attachment H for clinics closed to Category B and C veterans.)

- As a result of inadequate funding, VAMC San Francisco reports that they have suffered RAM losses totaling over $4 million from their recurring base the past four years. Unfunded expenses for the care of AIDS patients is $5 million for FY88 and $8 million (projected) for FY89. This situation reached such proportions that in June of '88 the VA Regional Director for the Western VA Region sent an urgent appeal to other VA medical centers in the Region to ask them to "loan" the San Francisco VAMC resources from their own accounts just to bail San Francisco out until the end of this year. (Attachment I)

- VAMC Richmond shows FY88 unfunded operating expenses of $2,570,008. Referrals of Category C veterans requiring services have been restricted due to current workload demands.

- VAMC Buffalo, N.Y., reports a total of $1,267,083 of unfunded operating expenses for FY88.

- VAMC Long Beach, CA, reports unfunded operating expenses well in excess of $2.5 million.

- PVA's Chapter, Eastern Paralyzed Veterans Association (EPVA), this summer, conducted a survey of inpatients at spinal cord injury centers at three VA Medical Centers in their geographical area - Castle Point, N.Y. VAMC; Bronx, N.Y.

VAMC; and East Orange, N.J. VAMC. Copies of the results of this survey have already been given to this Committee. In summary, the study showed increasing dissatisfaction among patients and staff with the amount and degree of care being given at these facilities. Bed and staffing reduction are tied directly to shortfalls in resources.

In response to the survey, the Associate Director at Castle Point VAMC wrote the following statements in a letter to EPVA Executive Director James J. Peters, clearly signalling his severe frustration with the lack of funds available to maintain current levels of care.

...."Due to staffing shortages in nursing, we were compelled to reduce our actual operating beds to 196 which we believe matched our staffing levels to ensure safe and adequate patient care. Although we have received approval of special salary rates for nurses and LPN's, there has been no impact relative to our ability to recruit new staff .....

The result of the resource allocation model indicates we will be reduced by at least $485,000.00 in FY89. Our supply costs (i.e., Pharmacy ward stock, etc.) increased by more than $800,000.00 in FY88 over FY87 and our Services are requesting significant increases beyond our expenditure rate in FY88 and FY89 . . .

. . . (Mr. Peters) the last paragraph of your letter says it best - 'The excuses of - we cannot hire staff, we don't have money, staff is not available are no longer valid.' I regret that our excuses must in all reality be accepted as fact." (The full text of this letter appears as Attachment J.)

- VAMC Kansas City, MO, reports: "Many of our outpatient clinics are overbooked so the next available appointment ranges from less than two weeks (September 6 for Neurology screening) to over four months (January 6 for General Medicine). Average waiting time is about two months. So, while there is no policy to delay treatment, the overload in clinics does, in fact, result in delay."

- VAMC Boise, Idaho, reports: "VAMC Admission Waiting lists: average waiting time for nonemergency clinic General Medicine - 3.5 months, General Surgery - 1 month, Ortho - 4 months, Ophthalmology - 3 months, Cardiology - 2 months, Urology - 1.5 months, Mental Hygiene - 2 months, Substance Abuse - 1 week. Ortho, Ophthalmology and Cardiology are being restricted to service-connected and Category A."

- VAMC Sepulveda, CA, states that they have not had to turn away any nonservice-connected veterans; however, they report unfunded operating expenses of $2,274,389 for FY88.

- VAMC Jackson, MS, reports FY88 unfunded operating expenses totalling $941,183.

- VAMC Gainesville, FL, reports FY88 unfunded operating expenses totalling $2,127,971.

- In addition to FY88 unfunded operating expenses of $1,286,668, VAMC Bay Pines, FL, reports that due to demand, treatment for nonservice-connected (Category B) veterans is not reasonably available in the following clinics: Allergy, Cardiology, Dermatology, Diabetes, Endocrine, ENT, General Medicine, GYN, Hypertension/Renal, Neurology, Obesity, Ophthalmology, Optometry, Orthopedic, Podiatry/Amb. Surgery, Pulmonary, Rheumatology, and Urology.

- VAMC Nashville reports an FY88 shortfall totalling $1,971,115.

- VAMC Murfreesboro, TN, reports FY88 operating expenses totalling $1,888,067.

- VAMC Augusta, GA reports FY88 unfunded operating expenses totalling $1,639,940.

Shortages of Registered Nurses in the VA

Mr. Chairman, as we stated previously, PVA's Department of Veterans' Benefits sent informal surveys to National Service Officers (NSO's) in the field. Most of the responses we received were a reflection of information provided by Medical Directors at various stations across the country. The survey, although not meant to be scientific in nature, did strongly support the presence of a severe nursing shortage in the VA. We asked the NSO's to report the number of RN's per number of operating beds for both the VA and a private-sector hospitals in the area.

In most instances, the number of RN's per bed in the private sector far exceeded the rate in VA hospitals. The shortage of RN's forces the VA to rely more heavily on LPN's and ancillary health personnel to staff its hospitals. But even that base is eroding. Recruitment and retention remains a serious problem. The number of RN's currently authorized by the VA is minimal at best, but basic policy is even more difficult to track since the Agency has yet to formulate and promulgate staffing guidelines. Without sound and comprehensive staffing guidelines, the VA has insulated itself behind an impenetrable wall of variables and as all veterans know, there is nothing more formidable than in invisible enemy.

John Fears, Director of VAMC Hines, Chicago, Illinois, offers the following perspective on the VA nursing shortage in response to our survey:

> "A current American Hospital Association (AHA) survey (1987) indicates that in private sector Illinois hospitals, the average registered nursing hours per patient day is 5.95 for medicine and surgery combined. VA Hines' average is 2.48 nursing hours/patient day for medicine and surgery (based on RN FTEE of 186.6 and ADC of 364 for medicine and surgery combined). Thus, patients in private-sector hospitals receive more than two times the amount of nursing care than they would receive in a VA hospital. This is true not only because we have fewer nurses, but because the nurses we do have out on the wards are spending more and more time doing non-patient types of activities; activities such as inputting data and orders into DHCP, patient escort, picking up supplies from SPD, bed cleaning, emptying trash, taking specimens to the lab, etc.
>
> Cut-throat competition exists throughout the Chicago area for recruitment of nurses. The VA is not at all competitive due to its cumbersome method of requesting special salary rates. Of the 400 RNT's we trained last year, one accepted a position here. The others refused, indicating that there are too few nurses on the ward, not enough support staff and low pay.
>
> The obvious question then becomes: why are the nurses spending more time doing non-hands-on types of activities? Because the ancillary support staffing levels are not what they should be, according to VACO standards. For example, based on the Manpower Planning Division Staffing Report for the first quarter FY 1988, "earned FTEE" levels exceeded "actual FTEE" levels in Building Management (Sanitation: 246.99 vs. 175.50); Clinical Lab (152.90 vs. 117.40); Medical Administration (296.16 vs. 269.38); Pharmacy (99.89 vs. 88.73); Rehabilitation Medicine (60.74 vs. 57.21); and Social Work (55.14 vs. 51.94). Historically, these support services have demonstrated a percentage of effectiveness (earned FTEE/actual FTEE x 100) well in excess of 100%. This means that we're doing more with less, and the nurses up on the wards are having to cover where our shortages are. Based on the few services which this report calculates "earned vs. actual", VAH Hines "earned" 101 more FTEE than we have. This equates to $3,434,000 more in salary dollars which we "earned" but which are not forthcoming.
>
> In the article "As Margins Fall, Executives Forge Survival Tools," Hospitals, March 20, 1988, pp. 48-52, a comparison was made regarding staffing levels and number of beds in the private sector. Using their methodology, we extrapolated what our FTEE per occupied bed percentage would be (please refer to enclosed graph). According to this article, private sector hospitals of 500 beds or greater have 5.16 FTEE per occupied bed. VA Hines has 3.01 FTEE per occupied bed. In order for us to match the private-sector standard,

we would require an additional 2,214 FTEE, and approximately $77,000,000 in salary dollars." (Attachment K)

- When asked to compare VA RN staffing with private-sector hospitals in the area VAMC Seattle responded: "We operate at the lowest RN to bed ratio and the lowest RN to patient ratio in the Seattle medical area."

The results of our informal survey regarding RN vacancies are as follows:

Region 1:

VAMC	RN Vacancies
1	0
2	23
3	unspecified but report 114 beds out of service due to workload reduction
4	0
5	0
6	60 (includes all nursing personnel)
7	25
8	unspecified
(3 responses) Total	108

Region 2: Data collected on 19 VAMC's as follows:

VAMC	RN Vacancies
1	50.5
2	0
3	29
4	28.5
5	30.1
6	5
7	43
8	7.7
9	6 (Experienced 30-40 FTE nurse reductions in FY 86)
10	13.6
11	10
12	3
13	1
14	3
15	3
16	10
17	1
18	2
19	12
Total	258.4 (19 responses)

Region 3: Data collected on 16 VAMC's as follows:

VAMC	RN Vacancies
1	28
2	9
3	28
4	4
5	5
6	24
7	34
8	13.6
9	12
10	34
11	1
12	0
13	26
14	12.3
15	16
16	25 (as of 6/30/88) 54 (as of 8/13/88)
Total	300.9 (16 responses)

Region 4: Data collected on 14 VAMC's as follows:

VAMC	RN Vacancies
1	26.4
2	27
3	21
4	31.3 (with reduction of 34 beds)
5	unspecified
6	35
7	2
8	29
9	38
10	4
11	0
12	12
13	28.1
Total	253.8 (12 responses)

Region 5: Data collected on 19 VAMC's as follows:

VAMC	RN Vacancies
1	10
2	2.9
3	17
4	unspecified
5	2
6	unspecified
7	13
8	5
9	24
10	1.7
11	unspecified
12	10
13	28
14	3
15	0
16	1
17	9
18	7
19	23.5
Total	157.1 (13 responses)

Region 6: Data was collected on 13 VAMC's as follows:

VAMC	RN Vacancies
1	43
2	48
3	17
4	72
5	17
6	42
7	6
8	0
9	9
10	listed as "none due to budget constraints"
11	10
12	11
13	20
Total	295 (13 responses)

Region 7: Data collected from 14 VAMC's as follows:

VAMC	RN Vacancies
1	10 "staffing for beds" 60 "staffing for patients" VAMC reports 15
2	15
3	unspecified but verified shortage
4	unspecified but verified shortage
5	25
6	0
7	0
8	unspecified but verified difficulty

9	unspecified	"There are no staff shortages because of Budget"
10	0	
11	17.3	
12	5	
13	15	
14	0	
Total	92.3	(10 responses)

In summary Mr. Chairman, PVA's service officers surveyed over 100 VAMCs. Of these, 89 VAMCs gave responses (or the NSO was able to obtain responses) to which numerical value could be assigned for numbers of existing RN vacancies.

In total, with just over one-half of the 172 VA medical centers reporting our informal survey reveals a total of more than 1,465.5 RN vacancies. In reality its most likely much, much more. Given the fact that RN to patient and RN to bed ratios are already considered low even when VAMC's have filled all authorized positions, the RN shortage in the VA is indicative of a quality of care problem which directly affects hospitalized veterans. Some may counter this argument by saying that nursing shortages are a national problem these days common to all health care systems, private and public. That is true. But the VA is not equipped either financially or administratively to respond and compete on an equal basis within the context of this national nursing shortage with the rest of the national health care sector.

PVA respectfully submits, Mr. Chairman, that denial of care comes in many forms. When a veteran calls for a nurse and one is not available...that is denial of care. When a hospital admission or surgical procedure is delayed because of inadequate staffing or bed closures, that too is denial of care.

Prosthetics

Mr. Chairman, also included in our informal survey were questions regarding the budget and funding of prosthetic equipment and supplies.

The provision of prosthetics to disabled veterans has been a long-time concern of PVA. Prosthetics, orthotics and other medical devices include items such as wheelchairs, leg braces, crutches, artificial limbs, lifting equipment and bathroom assistive devices. For PVA's members, as well as other severely injured veterans, the use of these devices can make the difference between living as normal a life as possible and remaining housebound or bed-ridden. For disabled individuals, prothetics are not options, they are requirements for quality of life. The delay in delivery of adequate and appropriate devices has a direct affect on the veteran for each day heor she is without these assistive devices.

As you know, PVA emphasized the importance of this issue at the House Committee on Veterans' Affairs hearing on the VA Budget on March 3, 1988. At that time, we identified a growing problem in the intentional delay in the provision of prosthetic devices and appliances which are so vital to the rehabilitation of disabled veterans. As a result of an analysis of an inquiry PVA directed to our service officers in the field at that time, we were able to provide this Committee with concrete examples that, in many instances, it takes weeks and months for an application to be filled and even then, the equipment provided is often times substandard, make-shift, outdated or inappropriate. The problem can be directly traced to the lack of clear identification within the budget allocation of each VA medical center for a specific line item which can designate funding levels for prosthetics and prosthetics only. The problem can be resolved if such a line item is designed and adhered to by VA central office direction and individual VA medical center disbursement policies. But, most important, the problem can be resolved if sufficient resources are given to each VA medical center to meet the prosthetic needs of that station.

As it stands now, the yearly prosthetics funding allocation for each VA medical center is unspecified within its budget for that purpose and lumped into the general medical care allocation. As the demand and cost of VA health care rise, the dollars to provide that care continue to shrink. An individual medical center director, under these circumstances, is increasingly tempted to "borrow" or transfer funds which should be used for prosthetics to pay for other services. We believe this to be a common and condoned practice in the VA system today and our most recent survey verified this belief.

Shifting funds from general prosthetics needs, quarter by quarter during any given fiscal year, a medical center director can only compensate for the

shortfall by delaying the provision or purchase of prosthetic equipment. If funding for prosthetics has run dry in a given quarter because a sizeable portion of the full allocation was shifted to other purposes, an application for a wheelchair, for instance, for an eligible veteran very often might have to wait until well into the next or subsequent quarter until the new quarterly allocation takes care of the pending backlog of prosthetic requests from previous quarters and sufficient funds are available to cover the cost of that wheelchair. In the meantime, as is happening in many cases, the veteran is furnished substandard, inappropriate or ill-fitting used equipment when funding is not available to provide new devices. Both the VA and the veteran suffer extreme inconvenience, particularly in the provision of state-of-the-art high tech equipment. Such equipment is mandatory for the rehabilitation needs and quality of life of disabled veterans.

When we reanalyzed the situation regarding prosthetics in preparation for today's hearing we can only conclude that these circumstances have not improved. In fact, in many instances, the situation has become far worse as we near the end of the fiscal year.

Again, Mr. Chairman, Administrator Turnage has said:

> We may not get all we want, but we get all we need to do our job well...

Mr. Chairman, the reports from the field indicate that not only are veterans unable to get what they want, a whole lot of them are not even getting what they need.

PVA offers a West Roxbury-Brockton VAMC memorandum as evidence of the compromised service veterans, in need of prosthetics, must endure. The memo is dated May 12, 1988, and we would like to specifically call your attention to item #5 which reads in part: (Attachment L)

> There are many items which will have to be delayed until July, and some which may have to be delayed until October. We are working with very limited resources. Please be as conservative as possible in prescribing equipment. Something provided for one veteran will mean that another may have to do without."

Mr. Chairman, there are veterans who are not getting what they need. Delay is a form of denial.

PVA will now provide a sampling of comments from our survey regarding prosthetic funding from across the country.

Region 1:
VAMC West Roxbury (Medical Director comment)
"We have reduced our prosthetic stock inventory by $30,000. There are pending requests amounting to $23,000 for which we have $10,000 remaining in the account for the remainder of the year..."

VAMC Batavia (NSO comment)
" Director states there are no back orders or backlogged time elements or funding shortage. However, in a conversation with the Chief of Staff on the National Service Officer's visit of August 2, 1988, the Chief was concerned over the fact that they did not have enough funds for the Prosthetics Department. The Director painted a nice picture, but the word around the medical center is that there are shortages in Prosthetics, Pharmacy and Nursing."

Region 2
VAMC Washington,D.C. (Medical Director comment)
"Funding shortages for Prosthetics Service amount to $120,000."

VAMC Richmond (Medical Center Director comment)
"As of August 19, 1988, 77 prosthetic orders, a total of $90,014, have been prepared and placed on hold because of budget constraints. Funding for the remainder of the year stands at $31,914. Orders on hold are being processed on a priority basis."
VAMC Butler (Medical Director comment)
"The amount of backlogged orders will be approximately $27,000 during the fiscal year."

VAMC Huntington (Medical Director comment)
"There are no order backlogs but prosthetics will exceed the allocated budget for FY 88 by approximately $40,000."

Region 3
VAMC Gainesville (Medical Director comment)
"There are no prosthetic orders delayed at this time because of a local funding shortage. However, due to increased nondiscretionary workload and a budget shortfall, it has become necessary to apply eligibility and medical criteria more rigidly prior to procurement of major medical equipment/ prosthetics. Should additional budgetary erosion occur in FY 89, it will be necessary to further restrict delivery of not only prosthetic items, but other direct medical care services in various outpatient care programs. As an example, the estimated dollar amount of reduction in inventories for drugs, medical supplies, and prosthetics as a result_of inadequate funds in this fiscal year is $650,000."

VAMC Bay Pines (Medical Director comment)
"We estimate there is a shortage of $450,000 for FY 89 in the Prosthetics Service for this Medical Center..."

VAMC Nashville (NSO Comment)
"Prosthetic Funding Shortages -$188,000-6 weeks, 60 orders backlogged."
VAMC Memphis (NSO comment)
"I contacted _____, Prosthetics Chief, and was told that there are no backlog orders, only shipping delays. They are having budgeting problems on a continual basis. For the entire fiscal year, they have been obligating the next quarter funds when they exhausted the current quarter funds.
Therefore, as we come to the close of the fiscal year they are currently $250,000 in the red. They will carry this over to next year's budget within one week of the fiscal year 1989. Due to the shortage of funds there are limited prosthetics on hand."

Region 4
VAMC Allen Park (Chief of Prosthetics comment)
"Additional funds of $150,000 for FCP 092 were requested in writing on August 2, 1988 and an additional $40,000 was transferred to FCP 092 to procure prosthetic appliances."

VAMC Indianapolis (NSO comment)
"The prosthetic account had to be augmented by $442,000 from reprogrammed equipment and maintenance accounts."

VAMC Cincinnati (Medical Director comment)
Prosthetics funding: "A current shortage of $71,700 exists as of August 25, 1988, with a back log of 222 orders of which the oldest order is 69 working days old."

Region 5
VAMC Columbia (Medical Director comment)
"We have identified an unfunded need of $190,000 in prosthetic funding for FY 1988."

VAMC Kansas City (Medical Director comment)
"There are currently some shortages in prosthetics. Some of these shortages will be covered with funds currently being received from VACO and Region."

VAMC St. Louis (Medical Director comment)
"Due to budget restraints, approximately $205,000.00 in third quarter orders were carried over for purchase in the fourth quarter. It is estimated that $200,000.00 is needed to meet orders expected through the remainder of this fiscal year."

VAMC Wichita (Medical Director comment)
"Current backlog amounts to $47,000. Purchases are pending additional funding on October 1, 1988."

Region 6
VAMC Loma Linda (Medical Director comment)

"A spot survey shows 592 prosthetic orders pending. A constraint of two orders per day (for emergent cases) is placed on order processing due to lack of funds. Our average delay in placing orders is six weeks. Generally, prosthetics is funded $600,000/year but requires $850,000 to fill eligible requests."

VAMC Martinez (Medical Director comment)
"$100,000.00 short, delay of 4 weeks on prescriptions."

Region 7
VAMC Oklahoma City (NSO comment)
"If $25,000.00 can not be transferred to Prosthetics from other sources within the hospital, backlog will be 30 days."

VAMC Dallas (NSO comment)
"There is continual strain on prosthetic funding. However, when a shortage occurs, surplus funds for other services or programs are rerouted to prosthetics."

VAMC San Antonio (Medical Director comment)
"Prosthetic funding shortages - $200,000"

Mr. Chairman, these comments are very telling. It is obvious to PVA that some veterans just are not getting what they need. We simply cannot accept on the basis of our findings Mr. Turnage's statement that "we may not get all we want, but we get all we need to do our job well."

Finally, it appears that ten years of cost-shifting and the rechanneling of program funds has finally caught up with the VA resulting in critical shortages throughout the system. Nicks and cuts in the VA system made in the name of "creative financing" have, over time, in actuality, created a series of unstable links which connect the veteran to VA health care delivery. Such erosion, over time, has created pitfalls which trip up the veteran on his road to recovery. Although the VA may not say to an eligible veteran, "you cannot come here," their message to sick and disabled veterans just well may be, "we don't have room for you here." In the end, the result is the same.

Mr. Chairman, it is time for a full and accurate accounting of the budget needs and priorities of the VA for the benefit of our nation's veterans and our nation as a whole.

ATTACHMENT A

VA outpatient clinic
San Diego, CA

ATTENTION -

EFFECTIVE MONDAY, AUGUST 15, 1988, PATIENTS REQUIRING URGENT OR UNSCHEDULED CARE WILL NOT BE SEEN AT THIS FACILITY.

THOSE PATIENTS SHOULD REPORT TO THE ADMISSION/TRIAGE AREA AT THE VETERANS ADMINISTRATION MEDICAL CENTER 3350 LA JOLLA VILLAGE DRIVE.

ATTACHMENT A1

VA OUTPATIENT CLINIC-SAN DIEGO

The VA Outpatient Clinic is making adjustments due to the loss of a nurse practitioner. The remaining 5 nurse practitioners include 4 who are full-time employees and 1 who works part-time(one day a week) in a special AIDS clinic. The patient caseload for the remaining professional employees has been increased since they must absorb the patients assigned to the lost nurse practitioner. The VA does not plan to fill the vacant position. Consequently, effective August 15, 1988 the Outpatient Clinic has posted notice (see enclosure) that patients requiring urgent or unscheduled care will not be seen. The patients are directed to the VA Medical Center which is approximately 12 miles northwest of the outpatient clinic. This rather drastic measure of turning away veterans seeking medical care is allegedly due to the loss of the nurse practitioner position.

Apparently the clerical staff is also being affected. Morale is reportedly low and the employees are sometimes required to work temporarily at the VA Medical Center due to the heavy patient caseload at that facility.

Veterans who have a medical urgency or insist on being seen without an appointment will be given a medical evaluation to determine the urgency of their medical condition. However, category C veterans are being denied medical care effective April 11, 1988 (see enclosed letter). These veterans are being advised to seek medical care in the private sector. Additionally, other veterans are given a future appointment when they report without an appointment. In the past, each nurse practitioner served as "Officer of the Day" resulting in veterans without an appointment being seen in most cases. This designation has been eliminated.

ATTACHMENT B

VETERANS ADMINISTRATION MEDICAL CENTER
DENVER, COLORADO

APR 14 1988

BULLETIN NO. 88- 48 (119)

NONREFILLABLE PRESCRIPTIONS

The products listed on the reverse side will no longer be refillable by Pharmacy Service. These products are self limiting as defined by their intended use and continuing need is not justified. These items are available to provide for a smooth transition from inpatient care to home care. When writing prescriptions for these items, you are reminded to consider carefully the time required for their use and to indicate the appropriate amount required on the prescription when forwarded to Pharmacy Service.

FRED SALAS
Medical Center Director

DISTRIBUTION:

116 - 25
11B - 20
127 - 5
111 - 30
112 - 20
136B - 20
119 - 30

EXPIRES: April 1989

ATTACHMENT B1

NONREFILLABLE OVER-THE-COUNTER MEDICAL SUPPLIES

BD PAD, STERILE 5x9
BDOMINAL PAD
CETAMINOPHEN 325mg TAB
CETAMINOPHEN 500mg/15cc ELIX (237ml btl)
LCOHOL ISOPROPYL
LCOHOL PREP PADS
AND, SZ 4 THRU 8 (BURN NET)
ANDAGE, ADHESIVE
ARRIER STERILE FIELD
EDSIDE DRAINAGE BAG
HUX, BLUE
AVOL 4105 TOP URINAL
AVOL 4157 URINAL BOTTOM
AVOL 4175 24oz LEG BAG
LASTIC GAUZE 3x5
IPHENHYDRAMINE 12.5mg/5ml ELIX
IPHENHYDRAMINE 25mg CAP
INE MESH GAUZE
AUZE 4x4 STERILE UNFILLED
AUZE PADS, TOPPERS 4x4
AUZE SPONGES, 2x2 STERILE
LOVE, COTTON
LOVES, NON-STERILE
LOVES, STERILE SURG
YDROGEN PEROXIDE
ERLIX 4½" ROLL
EG BAGS
ARTIN TRACH-SECURE
CGUIRE 050804 URINAL
ONTGOMERY STRAP
U GAUZE
U-HOPE WAIST AND OSTOMY BELT
P-SITE
AD, INCONTINENCE LARGE
ANTS, INCONTINENCE MEDIUM
PERMA-TYPE TAPE D-126L
POVIDONE IODINE GAUZE PADS
POVIDONE IODINE OINT AND SCRUB
POVIDONE IODINE PREP PADS
POVIDONE IODINE SOLUTION
POVIDONE IODINE SHAMPOO
PROTECTIVE BARRIER FILM WIPES
SWEEN CREAM
TAPE, 1" CLOTH (ADHESIVE)
TAPE, 1" PAPER AND TRANSPORE
TAPE, 1" DERMICLEAR
TAPE, 2" PAPER
TELFA PADS
TOLNAFTATE 1% SOLUTION
TOLNAFTATE 1% TOPICAL POWDER
TRACH BRUSHES
ULTRASOUND TRANSMISSION GEL
UNITED 1110 BONGORT
UNITED 3206 SEMI DISP POUCH
UNITED 3406 URINARY POUCH
UNITED 4023 UNI-SOLVE WIPES
UNITED 4026 UNI-SOLVE ADHESIVE REMOVER
UNITED 4050 URI-KLEEN PT
UNITED 4120 BANISH II 37.5ml
UNITED 4121 BANISH II 237ml
UNITED 4202 SKIN PREP AEROSOL
UNITED SKIN BOND 4oz
UREA 10% CREAM 75g
URINAL, PLASTIC
UROCARE 7001 DRAIN VALVE
UROCARE 8010 SPORT BAG
UROCARE DELUXE LEG STRAP KIT
UROLUX SOLUTION 16oz
VASELINE PETROLATUM GAUZE
XEROFORM DRESSING

ATTACHMENT C

VETERANS ADMINISTRATION
SALEM, VIRGINIA 24153

AUG 31,1988

[redacted]

Dear [redacted]

A consultation was sent to one of our specialty clinics for evaluation of your medical problems.

Currently this specialty clinic is only accepting service connected veterans for evaluation and/or treatment. For this reason, we are unable to schedule you for this clinic. We suggest that you seek care for this condition in the private sector at your own expense.

I regret that we are unable to assist you with this request. I am enclosing a phamplet that explains your eligibility for medical benefits. Should you have any additional questions, please call Mr. Williams at (703) 982-2463, extension 2350 or Mrs. Harrah, extension 2824.

Sincerely yours,

DONNA S. LANCASTER, Chief
Medical Administration Service

Enclosure

America is #1
Thanks to the Veterans

DAILY BULLETIN

THURSDAY, APRIL 7, 1988

Veterans Administration Medical Center San Diego, CA.

ADMITTING AND TRIAGE OFFICERS

8:00 AM - 8:00 AM -- 24 HRS. (MOD) — 5:00 PM - 8:00 AM (SOD)

Dr. Videen — Dr. Auerhan/#412 ATTACHMENT I

DESIGNATION

SERVICE	ABSENT	ACTING	DATE
Chief of Staff	J. G. Parthemore, M.D.	L. Henderson, M.D.	4/7/88

****

EARTHQUAKE PREPAREDNESS MONTH

Here's today's tip to help you prepare for and survive a major earthquake in Southern California.

Store three to seven days' supply of non-perishable food for emergency use. Be sure you have a non-electric can opener and utensils to eat with and cook in. Camp stoves, charcoal fired and bottled gas barbecues can be used for heating foods. Rotate your emergency food supply with your regular canned goods to ensure against spoilage.

San Diego Be Aware -- Prepare!

****

SERVICE TO VETERANS IN ELIGIBILITY CATEGORY "C"

Effective Monday, April 11, 1988, this Medical Center (to include the Mission Valley Outpatient Clinic) will begin to discontinue the provision of service to veterans in eligibility category C. This discontinuation of service is due to a decline in the availability of resources. Medical Administration Service will be developing the implementation plan for this change and they will be disseminating this information to the staff. It is important to remember during this process of curtailment that it is Medical Administration Service who will make the eligibility determination and advise the veterans. All veterans will receive an evaluation to determine the urgency of medical care required, however, not all veterans will be entitled to the recommended future care.

This will be a difficult time for all of us, but more importantly for those veterans who will be informed that they will not be able to receive care.

Should you have any questions concerning this, please contact John Corrow or Rene Duhamel at extension 3474.

ATTACHMENT E

Medical Center
San Diego

Veterans Administration

In Reply Refer To: 664/136

Dear Veteran:

It is with great regret that I must advise you of some measures that we must take to reduce the workload at this Medical Center and the Mission Valley Outpatient Clinic.

Effective April 11, 1988, we will begin a process to discontinue services to those veterans who are in the eligibility category C. You have been identified as one of them. This measure has been necessitated because of the decline of available resources. According to established guidelines, veterans in the eligibility status of category C, can be afforded medical care based on available resources at the veteran health care center to which they are applying. Our resources at this point have declined and as such, we must begin to reduce our extremely high workload.

For those category C veterans who have future appointments or admissions scheduled, we ask that you contact our Health Benefits Advisor at 453-7500 extension 3926, for further guidance.

All veterans who report to the Medical Center or the Mission Valley clinic will receive a medical evaluation to determine the urgency of their medical condition, however, category C veterans will not be entitled to care at this facility for the foreseeable future.

For those of you who are receiving medications from our pharmacy, we will be honoring refills for up to two months to allow you the opportunity to obtain medical services from a private physician.

We sincerely regret that this action must be taken and only hope that we can again open our doors to category C veterans at some time in the future.

Sincerely,

Jule D. Moravec

JULE D. MORAVEC, Ph.D.
Acting Medical Center Director

Veterans Administration

Memorandum

ATTACHMENT F

Date: August 5, 1988

From: Director (00)

Subj: Rescission of previously authorized personnel ceilings and authority to recruit

To: All Service Chiefs

1. The best available estimates indicate that we will have to reduce expenses for FY 1989 by about two million dollars. I have appointed a Budget Deficit Task Force to develop a viable plan for doing so while still maintaining adequate revenues. No activities, programs, or Services are exempt from consideration for cuts. New personnel ceilings for FY 1989 will be determined on the basis of the final plan for budget cuts. Consequently, previously authorized personnel ceilings for all Services must be rescinded, and urgently needed positions will be filled only on a case-by-case basis. Urgent personnel needs should be addressed to the Chief, Personnel Service for processing. All previously issued authorizations to recruit replacement employees are hereby rescinded. Commitments that have already been made will be honored but only if Personnel Service attests that a commitment has in fact been made.

2. The Budget Deficit Task Force and I personally are committed to keeping the Medical Center operating as efficiently and effectively as possible. To do so will require cuts and a likely reorganization of some programs and activities. There are no plans to RIF or Furlough any employees but we must operate within the funds available.

3. RESCISSION: None

Mary Ann Coffey

MARY ANN COFFEY

Dist: B

Ioannis A. Lougaris
VA Medical Center
1000 Locust Street
Reno, NV 89520

ATTACHMENT G
COPY
for
MAA's
Rae
& file

554/11

June 29, 1988

Mr. David R. Brady
Assistant Vice-President
Mercy Ambulance of Reno
1050 Bible Way, #5
Reno, NV 89502

Dear Mr. Brady:

As discussed in our telephone conversation today, we ask that REMSA ambulance service avoid bringing patients with SUSPECTED CARDIAC ISCHEMIA to the Reno VA Medical Center, effective immediately.

This Medical Center has no staff cardiologist, and is unable to provide prompt and appropriate care for such patients.

After these patients are assessed and stabilized at other community medical centers, we will arrange for their transfer to the VA on a space-available basis.

Sincerely,

PAUL R. JENSEN, M.D.
Chief of Staff

SHEILA M. CULLEN
Acting Director

bc:

001
136
170

[illegible] 1000 S COLUMBIAN WAY, SEATTLE, WA 98108
OPEN AND CLOSED CLINICS--APRIL, 1988

ATTACHMENT H

Consult forms in DUPLICATE are required.

CLOSED CLINICS: MUST be service-connected or posses Special Entitlement
Strictly NSC consults will not be forwarded by MAS personnel.

	CLINIC MANAGER
ANTI-COAGULATION-111M	NANCY ROBEN,RN
ARTHRITIS	GORDON STARKEBAUM,MD
AUDIOLOGY	ROBERT MILLER,MD
CARDIOLOGY	JAMES RITCHIE,MD
DAY TREATMENT	REX JOHNSON
DENTAL	DAVID HEID,DDS
ENDOCRINOLOGY/METABOLISM-151 ENDO/META	WILLIAM BREMNER,MD
ERECTILE DYSFUNCTION/IMPOTENCE-112GU	ROBERT IRETON,MD
GASTROENTEROLOGY(GI)-111GI	CHARLES POPE,MD
GERONTOLOGY(GRECC)-182B	MURRAY RASKIND,MD
HEMATOLOGY	GERALD ROTH,MD
HOSPITAL BASED HOME CARE(HBHC)	DENISE SHEA,RN
HYPERTENSION(HTN)-111HTN	DONALD SHERRARD,MD
INSULIN THERAPY	WILLIAM BREMNER,MD
MEDICAL COMPREHENSIVE CARE UNIT-111M	STEPHEN FIHN,MD
MENTAL HYGIENE GENERAL	REX JOHNSON
NEUROLOGY-127	THOMAS BIRD,MD
OPHTHALMOLOGY-112OPH	MICHAEL VANBROCKLIN,MD
OPTOMETRY-112OPH	MICHAEL VANBROCKLIN,MD
ORTHO-BACK(must be SC for back condition)	THEODORE GREENLEE,MD
ORTHO-HAND,NEW,FOLLOW-UP	THEODORE GREENLEE,MD
PODIATRY-112POD	JOAN WILLIAMS,DPM
PULMONARY	R.K. ALBERT,MD
REHABILITATION MEDICINE(RMS)-117	EUGENE HALAR,MD
RENAL/NEPHROLOGY	DONALD SHERRARD,MD
SEIZURE-127	THOMAS BIRD,MD

PEN CLINICS	CLINIC MANAGER
LCOHOL TREATMENT	REX JOHNSON
ENIGN PROSTATIC HYPERTROPHY	STEPHEN FIHN,MD
AY HOSPITAL	REX JOHNSON
ERMATOLOGY	GREGORY RAUGI,MD
IABETIC FOOT ULCER-111M	JESSE AHRONI,ARNP
RUG DEPENDENCY TREATMENT	REX JOHNSON
AR/NOSE/THROAT(ENT)-112OTO	ALLEN HILLEL,MD
ENERAL SURGERY	H.M. RADKE,MD
YNECOLOGY-111M	PATTI PAYNE,RN
UNG CANCER-111ONC	JACK SINGER,MD
UNG EDUCATION(PULM)	NANCY RISSER,RN
ENTAL HYGIENE SELECTED CLINICS	REX JOHNSON
EUROSURGERY	KIM BURCHIEL,MD
NCOLOGY-111ONC	JACK SINGER,MD
AIN CLINIC-112ANESTH	LOUIS JACOBSON,MD
ERIPHERAL VASCULAR SURGERY(PVS)	EUGENE ZIERLER,MD
LASTIC SURGERY-112	JORDON GOTTLIEB,MD
INAL CORD INJURY(SCI)	CATHERINE BRITELL,MD
OKING COUNSELING(MCCU)	NANCY RISSER,RN
ECIAL DIAGNOSTIC PROCEDURES	SENT TO SERVICE
OLOGY-112GU	ROBERT IRETON,MD

inics with mail stops require the consult to be sent to the service office, all closed inic referrals must go thru 136B for eligiblity determination. Any consults not quiring eligiblity determinations may be sent directly to Centralized Scheduling.

Department of Medicine
and Surgery
Western Region

211 Main Street
San Francisco CA 94105

Veterans Administration

ATTACHMENT I

June 2, 1988

In Reply Refer To: 10BA6

Directors (00)
All Western Region Medical Facilities

SUBJ: Financial Condition of VAMC San Francisco.

1. The Medical Center at San Francisco is facing a significant financial deficit in FY 88. Addressing the problem is a region wide responsibility and requires resolution prior to September 30, 1988.

2. This letter is a request for all facilities to review their status of funds and volunteer to provide a loan to the San Francisco Medical Center in FY 1988. Funding is needed in the fourth quarter of FY 1988. Repayment of the loan, by VAMC San Francisco, will be accomplished over the shortest period of time possible i.e., 1-3 years and will be effected by adjustments to the facilitys' AACS prior to the start of each fiscal year of the payback period.

3. Although this letter is confidential, Directors will want to share its content with their Chiefs of Staff and Associate Directors. To volunteer a loan in FY 1988 and collect funding back in future fiscal years should have the full support of the medical center triad.

4. Confidential letters concerning funds available for loan should be sent to my attention. A response to this request by June the 17th, 1988 would be appreciated.

R. E. Lindsey Jr.

R. E. LINDSEY JR.
Regional Director
Western Region

ATTACHMENT I 1

WESTERN REGION (10BA6)
211 MAIN ST., SUITE 1800
SAN FRANCISCO, CA 94105

June 7, 1988

10BA6

Medical District Director (MDD26)
Medical District #26
VAMC Menlo Park Division
795 Willow Road
Menlo Park, CA 94025

SUBJ: Contingency Plan for VAMC San Francisco

1. The Medical District 26 staff is requested to coordinate a district contingency plan to care for VAMC San Francisco patients should VAMC San Francisco deplete their operating funds the fourth quarter of this fiscal year. As we have discussed, I have initiated action within the Western Region to solicit funds for a loan for VAMC San Francisco to augment their budget this year. If funds are not available within the region and/or the San Francisco Medical Center's estimate of this deficiency is not correct, we must develop a plan so that there is the least possible disruption to patient care activities and the quality of patient care is not affected.

2. I have discussed development of a contingency plan with the Acting Director at VAMC San Francisco. I have also discussed the issue with the Acting Director, VAMC Martinez and the Director at VAMC Palo Alto, and they will serve as the backup facilities for VAMC San Francisco. All three Directors will designate someone on each of their staff to work with the medical district staff in developing the contingency plan.

3. You are requested to submit a copy of the completed plan to my San Francisco office by cob June 30, 1988. Thank you for your cooperation.

R. E. LINDSEY, JR.
Regional Director
Western Region

Signed And Dispatched

cc:
VAMC San Francisco (00)
VAMC Palo Alto (00)
VAMC Martinez (00)

Medical Center Castle Point NY 12511

ATTACHMENT J

July 1, 1988

In Reply Refer To: (533/001)

Mr. James J. Peters
Executive Director
Eastern Paralyzed Veterans Association
432 Park Avenue South
New York, NY 10016

Dear Mr. Peters:

I have received your letter of June 27, 1988 along with the results of your recent survey.

Let me begin my response by thanking you for the responsible and professional manner in which your survey was accomplished. We also wish to thank you for your words of praise for our staff. We agree that our staff are among the best in the Veterans Administration medical care system.

The contents of your survey, as it relates to individual support Services, are being provided to those Services along with the request to incorporate, where appropriate, those issues which should be included as part of our quality assurance program.

The issues of staffing and numbers of beds are much more complex matters to completely address. You are correct in stating Spinal Cord Injury at Castle Point is an authorized sixty bed program but, as I'm sure you recall, we will eventually reduce to 56 beds as a result of renovations on Wards E-1 and D-1, with six of those beds designated for plastic surgery on Ward D-1.

Several issues about bed composition for the near future must be clearly explained. Due to staffing shortages in Nursing we were compelled to reduce our actual operating beds to 196 which we believe matched our staffing levels to ensure safe and adequate patient care. Although we have received approval of special salary rates for Nurses and LPN's, there has been no impact relative to our ability to recruit new staff. This is a dilemma for which we have no answer and it indeed remains a major problem for the entire nation. Needless to say, as the summer months approached, we became very concerned about our ability to allow any of our nursing personnel to take vacation time without severely compromising safe patient care. We chose to reduce 12 additional beds for the

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2.

Mr. James J. Peters

summer months which included a reduction of four in SCI. We sincerely regret the necessity of this decision but I think you will agree that our staff must be granted some relief or we may lose additional staff.

The long term situation for total beds calls for the final composition of beds to be as follows:

E-1	32	SCI
D-1	24	SCI
E-2	42	MED/INT.
D-2	0	WILL REMAIN CLOSED
E-3	42	MED/INT.
D-3	39	SURG.
MICU/SICU	8	
NEW WING	30	INT./REHAB.
TOTAL	217	

The above numbers will require adjustments for the next three years for several reasons. The new ward will be the swing ward as we do ward renovations. Please note the new ward has a 30 bed capacity while most of the wards being renovated have larger capacities. We believe that due to renovations and staff shortages we will be operating at between 178 and 196 beds for at least the next three years.

Lastly, let me advise you that our budget hearings will be held in mid July. The result of the resource allocation model indicates we will be reduced by at least $485,000.00 in FY 89. Our supply costs (i.e., Pharmacy ward stock, etc.) increased by more than $800,000.00 in FY 88 over FY 87 and our Services are requesting significant increases beyond our expenditure rate in FY 88 for FY 89. I know you are aware that we must fund our essential supplies and the remaining budget dictates the level of staffing we are able to support. We also believe we may be asked to absorb part or all of the proposed January pay raise. Additionally we may have a further one percent productivity cut.

3.

Mr. James J. Peters

The scenario we present is factual as we understand it. This facility must now reconsider its total mission and consider reductions in services if we are to function in a rational way at least for the near future.

The last paragraph of your letter says it best: "The excuses of we cannot hire staff, we don't have money, staff is not available, are no longer valid." I regret that our excuses must in all reality be accepted as fact.

Please continue to support Castle Point as you always have and believe me when I say we hear your concerns and share your frustration.

Sincerely yours,

for Canton

JIM A. FERGUSON
Associate Director

Edward Hines, Jr.
Hospital

Hines IL 60141

ATTACHMENT 1

Veterans
Administration

August 24, 1988

In Reply Refer To: 578/00A

Carmen Gonzalez, Jr.
National Service Officer
Paralyzed Veterans of America
V.A.R.O., Room 400
Federal Building
536 S. Clark Street
Chicago, IL 60605

Dear Mr. Gonzalez:

The following information is forwarded in reply to your memorandum dated August 11, 1988:

Item #1: Clinical Staff Shortages (as of 8/24/88):

Ambulatory Care	.5 FTEE Health Technician
Blind Rehab	3.0 FTEE Blind Rehab Specialists
	1.0 FTEE Medical Clerk
Diagnostic Radiology	1.0 FTEE Neuroradiologist
	1.0 FTEE General Radiologist
	1.0 FTEE Diag Rad Technician
	1.0 FTEE Medical Clerk
Dietetic	3.0 FTEE Dietitians
	1.0 FTEE Diet Technician
	5.0 part-time Service Workers
Extended Care Center	6/8's MD
	5/8's MD
Lab	8/8's MD
	4/8's MD
	4.0 FTEE Medical Technologists
	1.0 FTEE Histology Path Tech
	2.0 FTEE Medical Technicians
Medicine	2.0 FTEE Respiratory Therapists
	2.0 FTEE Hemo Techs
Neurology	6/8's MD
Nuclear Medicine	2.0 FTEE MD's
	2.0 FTEE Nuclear Medicine Technologists
Nursing	27.0 FTEE RN's
	40.0 FTEE LPN's and NA's
Pharmacy	1.0 FTEE Chief
	1.0 FTEE Clinical Pharmacist
	1.0 FTEE Pharmacy Tech
Prosthetics	1.0 FTEE Asst. Chief
Psychiatry	2.0 FTEE MD's
	2.0 FTEE Rehab Techs

K 1

Psychology	1.0 FTEE Clinical Psychologist
	1.0 FTEE Vocational Rehab Specialist
Rehab	1.0 FTEE Manual Arts Therapist
	1.0 FTEE CT
	5.0 FTEE OT's
	4.0 FTEE PT's
Social Work	5.0 FTEE Social Workers
Surgical	1.0 FTEE Nurse Anest.

Item #2: Admission Waiting Lists: There is not currently a formal means for collecting or reporting the number of individuals on the waiting list for elective surgery. We were able to determine, however, that there are currently six patients awaiting plastic surgery for decubitis.

Item #3: Category B, C Treatment Referrals: We do not have a policy for deferring treatment or stopping treatment of Category B, C veterans, nor do we turn NSC veterans away or delay treatment in OPC's.

Item #4: Prosthetic Funding Shortages: Our current backlog of orders is minimal. This is because the Chief, Prosthetic Treatment Center has taken a very active role in improving the efficiency of his Service. Specific examples include no longer issuing backup wheelchairs; no longer issuing sports wheelchairs; we are renting more equipment with an option to buy once funds become available; we are suggesting against specialized orders; some OT equipment has been discontinued; very strict medical need criteria are applied against each request; we are extending the life of equipment by repairing it beyond the 50% mark; and we are reissuing and refurbishing many more items than in the past (over 22% as compared to the last FY). We are very proud of the fact that we have the lowest cost per issue for the Great Lakes Region.

Item #5: Facility Budget Info:

	FY87	FY88	FY89(TA)
Workload Reductions	- 2,625,583	0	0
RAM Adj.	+ 1,029,063	+ 910,478	- 1,814,104
Productivity Adj.	- 867,292	- 357,078	- 937,855
Unfunded Inflation Cost	- 1,200,000	-1,000,000	- 800,000
MEDIPP Tax	0	0	- 588,540
Unfunded Special Salary Rates	- 194,867	- 991,338	- 618,980
DHCP Savings	0	- 77,005	- 111,185
CALM Savings	0	0	- 45,095
Homeless Taxes	0	0	- 291,073
Other	0	0	0
TOTALS:	- 3,858,679	- 1,514,943	- 5,206,832
Total FTE Adjustments	+ 9.3	- 96.2	- 85.8

Item #6: Number of nursing vacancies as of 6/30/88: 27.1 RN's and 36.2 LPN's

Item #7: RN Staffing compared to private sector:

Number of RN FTEE: 636
Number of Operating Beds: 1, 144 (Hospital), 1,383 (Hospital + Extended Care Center)

K2

A current American Hospital Association (AHA) survey (1987) indicates that in private sector Illinois hospitals, the average registered nursing hours per patient day is 5.95 for medicine and surgery combined. VAH Hines' average is 2.48 nursing hours/patient day for medicine and surgery (based on RN FTEE of 186.6 and an ADC of 364 for medicine and surgery combined). Thus, patients in private-sector hospitals receive more than two times the amount of nursing care than they would receive in a VA hospital. This is true not only because we have fewer nurses, but because the nurses we do have out on the wards are spending more and more time doing non-patient types of activities; activities such as inputting data and orders into DHCP, patient escort, picking up supplies from SPD, bed cleaning, emptying trash, taking specimens to the lab, etc.

Cut-throat competition exists throughout the Chicago area for recruitment of nurses. The VA is not at all competitive due to its cumbersome method of requesting special salary rates. Of the 400 GNT's we trained last year, one accepted a position here. The others refused, indicating that there are too few nurses on the ward, not enough support staff and low pay.

The obvious question then becomes: why are the nurses spending more time doing non-hands-on types of activities? Because the ancillary support staffing levels are not what they should be, according to VACO standards. For example, based on the Manpower Planning Division Staffing Report for the first quarter FY 1988, "earned FTEE" levels exceeded "actual FTEE" levels in Building Management (Sanitation: 246.99 vs. 175.50); Clinical Lab (152.90 vs. 117.40); Medical Administration (296.16 vs. 269.38); Pharmacy (99.89 vs. 88.73); Rehabilitation Medicine (60.74 vs. 57.21); and Social Work (55.14 vs. 51.94). Historically, these support services have demonstrated a percentage of effectiveness (earned FTEE/actual FTEE x 100) well in excess of 100%. This means that we're doing more with less, and the nurses up on the wards are having to cover where our shortages are. Based on the few services which this report calculates "earned vs. actual", VAH Hines "earned" 101 more FTEE than we have. This equates to $3,434,000 more in salary dollars which we "earned" but which are not forthcoming.

In the article "As margins fall, executives forge survival tools," Hospitals, March 20, 1988, pp 48-52, a comparison was made regarding staffing levels and number of beds in the private sector. Using their methodology, we extrapolated what our FTEE per occupied bed percentage would be (please refer to enclosed graph). According to this article, private-sector hospitals of 500 beds or greater have 5.16 FTEE per occupied bed. VAH Hines has 3.01 FTEE per occupied bed. In order for us to match the private-sector standard, we would require an additional 2,214 FTEE, and approximately $77,000,000 in salary dollars.

Feel free to contact my Management Support Administrator, Mr. George A. Welton, at (312) 343-7200, extensions 2511 or 2512 if you have any questions regarding this response. Thank you for the opportunity to provide this information to you.

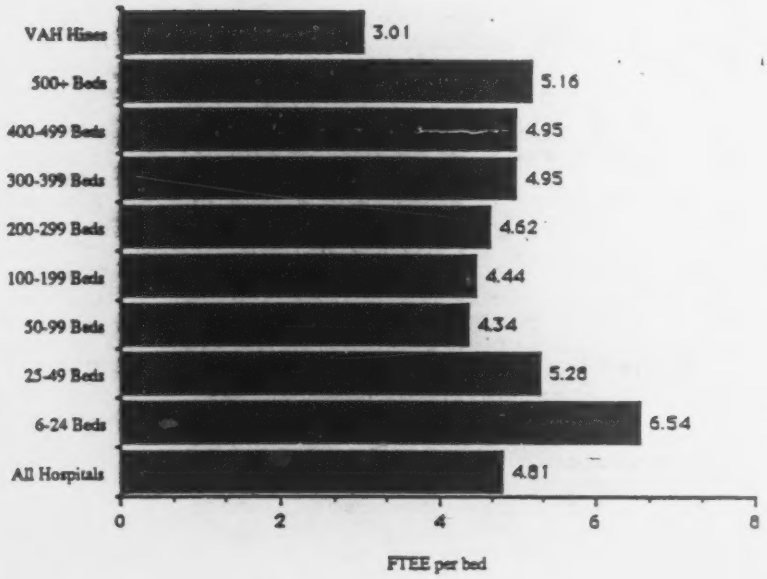
William R Best MD

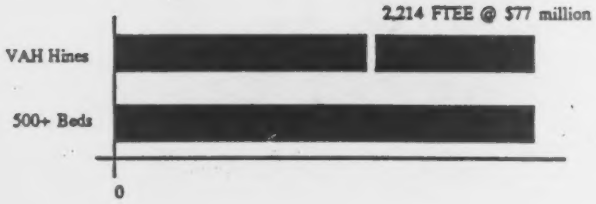
"FOR AND IN THE ABSENCE OF"
JOHN R. FEARS
Director

Enclosure

K3

Comparison of VA Hines Hospital FTEE per Occupied Bed with that Reported in Community Hospitals:





Source: "As margins fall, executives forge survival tools," Hospitals, March 20, 1988, pp 48 - 52.

Veterans Administration

Memorandum

WPST ROXB
VAMC

May 12, 1988

Chief, Prosthetics & Sensory Aids Service (121)

Prosthetic's Operating Budget

ATTACHMENT L

Clinical Service Chiefs

This is to inform you of the status of the Prosthetics' operating budget as of this date.

1. The entire third quarter budget has been spent. Additional funding has been requested but will not be made available.

2. The only funds that will be available between now and Oct. 1 is our fourth quarter budget, $79,500, which has already been cut to $77,500.

3. I have requested an advance on our fourth quarter budget of $24,600 to enable me to purchase some items which are medically urgent and cannot be delayed any longer.

4. This leaves a total of $52,900 operating funds available for Prosthetics between now and Oct. 1, 1988. There is no indication that any more funds will be made available in the fourth quarter.

5. There are many items which will have to be delayed until July, and some which may have to be delayed until October. We are working with very limited resources. Please be as conservative as possible in prescribing equipment. Something provided for one veteran will mean that another may have to do without.

6. With the help of our Orthotic Lab we are doing all we can to repair and reissue equipment whenever possible. Only items determined to be medically urgent will be ordered. Anything that can be delayed, temporized, or substituted will not be ordered at this time. Your patience and cooperation will be appreciated.

David J. Chandonnet
DAVID J. CHANDONNET

CC: Ernest M. Barsamian, M.D.
Acting Medical Ctr Director

Roger Johnson, Acting Associate Director

Prosthetics Staff - West Roxbury

Prosthetics Staff - Brockton

VA FORM SEP 1984 2105

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

from

JOHN F. SOMMER, JR., DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

to the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

on

VA HEALTH CARE OVERSIGHT, FUNDING PROBLEMS

SEPTEMBER 7, 1988

STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
SEPTEMBER 7, 1988

Mr. Chairman and Members of the Subcommittee:

The American Legion is appreciative of this opportunity to express its concern regarding the inadequate funding and management problems facing the Veterans Administration's Department of Medicine and Surgery.

Through site visits made to VA medical centers across the country, conducted by our National Field Representatives, and through information provided by our Department Adjutants, Department Service Officers and other concerned American Legion officials, a picture of fiscal distress is becoming apparent as VA medical centers strive under the most difficult of circumstances to provide quality medical care to veterans. As the fourth quarter of FY 1988 is now underway, we are aware of serious budgetary shortfalls at many VA medical centers.

A partial list of the problems include bed closures, curtailment of certain treatment programs, reduction of treatment to nonservice-connected veterans, excessive waiting times for admission and to be seen at certain outpatient clinics, and the closing of some clinics, just to name a few. We will discuss certain of these problems in more detail in a moment.

As we understand it, a myriad of factors are responsible for the current fiscal crisis. It is a fact that the budget for the Department of Medicine and Surgery has been decremental over the past several years. Experience verifies this as we visit medical centers which have continually attempted to do more with less. Dollars withdrawn for the one percent productivity incentive, workload reductions, Gramm-Rudman-Hollings reductions, as well as escalating costs for drugs, supplies, and medical technologies, all have created a scenario where the budget has progressively become totally inadequate. What we are witnessing today, is the cumulative effect of several years of funding deficits, coupled with the fact that the demand for care continues to increase. Through the end of July, the actual inpatient workload was averaging four percent above the fiscal year-to-date plan and the outpatient workload was approximately three percent above plan.

Mr. Chairman, as was recently stated by a VA official, "the level of budgetary anxiety in the field today is higher than ever before."

The Department of Medicine and Surgery is in a predicament today whereby

workload caps have been in effect at some facilities, and additional budgetary restraints relating to pharmacy and prosthetics services, have been imposed at others, as mentioned a moment ago. We are aware that several facilities have imposed Category C restrictions, and others are considering such restrictions.

Several current examples and vivid illustrations of field level constraints that have been reported to us are as follows:

- VAMC San Diego and Mission Valley Outpatient Clinic have discontinued treating Category C outpatients after one visit. The alternative for a Category C veteran is to seek treatment in the community.

- Various facilities are out of prosthetics funding, one example being Nashville. These facilities are delaying furnishing prosthetics equipment as ordered, from quarter to quarter.

- A policy of not providing prosthetics equipment to nonservice-connected outpatients has been in effect at the Boise, Nashville, Wichita and San Francisco VAMCs.

- A Halfway House in Miami, Florida, treating substance abuse patients, was closed on July 1, citing no available funds.

- The Washington, DC and the Biloxi, MS VAMCs were among those which were unable to pay community nursing home contract costs, although we have been advised that Washington, DC has now resumed placing veterans in community nursing homes.

- One of two rural health care clinics in Utah was closed, effective July 1. The other clinic is under budgetary scrutiny and is expected to be closed in September.

- Elective surgeries are delayed for many veterans, some up to a 25-week wait (based on the VA's own survey).

During a recent official visit in Des Moines, Iowa The American Legion National Commander John P. "Jake" Comer learned of the move to limit access to all Category B and C veterans at the Iowa City VAMC, and immediately called the office of the Administrator of Veterans Affairs expressing outrage over such a policy. Shortly thereafter, Medical Center officials in Iowa City and other facilities where

similar restrictions had either been implemented or were being considered, were reportedly told to reverse their decisions and to resume the provision of care based on established eligibility guidelines.

The National Commander was unaware at the time he placed the call of the similar restrictions being placed in effect at, among others, the Boise, Fargo and San Diego Medical Centers. As National Commander Comer has stated, the proper way to deal with such realities is for the Veterans Administration to submit realistic budgets to Congress each year, and not continue to say they can make do.

Mr. Chairman, these examples represent only some of the problems that have developed as a result of inadequate funding.

We understand that medical centers are shifting funds from equipment and non-recurring maintenance accounts to help fortify medical care programs and to support personnel salary costs. A facility may be able to operate in this manner for a year or two, but after a short while, the facility's physical plant, technology requirements and inventories will suffer. Additionally, operating beds have been placed out-of-service due to inadequate staffing, or due to an effort to economize resources. During a recent VAMC survey visit, a Field Representative observed first hand that eight non-acute psychiatric patients, who otherwise would have been admitted, were told to return the following day because no beds were available.

The number of operating beds out-of-service due to system-wide staffing vacancies are numerous and, in many instances, are causing unnecessary delays in the patient admission process. Oftentimes, a bed count has to be conducted to determine the number of daily discharges, so a decision can be made on how many beds are available and, thus, how many patients can be admitted.

Mr. Chairman, it is a well known fact that during recent visits to sixteen VA medical centers, Congressional staffers from this Commitee found that 1,771 hospital beds which were officially designated as operating beds were not available for the provision of medical care due to insufficient staff. Other beds were also closed for other reasons. It must be kept in mind that this is only a fraction of the total number in the system.

It has been estimated that the shortfall for FY 1989 may be as much as $819.3 million or more for the Department of Medicine and Surgery. Unless a supplemental appropriation is provided, we can only anticipate that, based on the projected funding deficit, even more draconian actions will be taken throughout the medical care system to

reduce spending.

As you are aware Mr. Chairman, the recently passed supplemental appropriations bill, H.R. 5026, contained $508 million for the VA for FY 1988, including $498 million for the compensation COLA that was approved in December 1987. The remaining $10 million is earmarked for VA health care. In addition, $21 million has been reprogrammed from the Home Loan Revolving Fund to the Department of Medicine and Surgery. However, the entire $31 million is to fund the provisions of PL 100-322 for the remainder of FY 1988.

Mr. Chairman, The American Legion has historically expressed the importance of maintaining an appropriate funding level for VA health care programs. Today, we are witnessing an increasing level of frustration on the part of VA hospital officials and related health care personnel, as they attempt to provide high standards of health care to eligible beneficiaries. This is in addition to the frustrations experienced by the veterans themselves. Contrary to being told by Veterans Administration officials in Washington that resources are sufficient to adequately carry out the mission of the Department of Medicine and Surgery, the only conclusions we can reach are that either resources are not well managed, or the requested funding levels have been insufficient to begin with. The shortfall in VA funding is real and no amount of wishful thinking will make it otherwise. As stated at the outset, The American Legion believes that the decremental - or straight-line funding that has been provided for medical care over a period of years is the major problem.

The fact of the matter is that the decremental budgeting has had an adverse effect on patient care and will continue to erode the quality, quantity and timeliness of health care services provided to veteran beneficiaries. We sincerely trust that VA officials will explain to this Subcommittee the true extent of the problems that are being experienced in the medical care system, and that they will accurately portray the budgetary requirements of the Department of Medicine and Surgery.

Mr. Chairman, this concludes our statement.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

HON. GERALD B.H. SOLOMON TO VETERANS' ADMINISTRATION

CONGRESSMAN SOLOMON

Question: 1. On page 9 of your statement you make reference to the Department's Resource Allocation Model which you call RAM. In visits around the country to VA medical facilities, our staff members were often told of RAM winners and RAM losers. Would you please comment on this matter?

Answer: The Resource Allocation Methodology or RAM is a management tool which allows us to compare the efficiency of facilities to one another, and to the system as a whole, and to adjust funding levels in relation to efficiency. Basically, the RAM, by means of three patient classification models (inpatient, outpatient and long term care), measures both the volume and the mix of patients treated by each facility. Within each facility, these measurements of patient workload are converted to indices of output called "Weighted Work Units" or WWUs which are divided into expenditures to determine efficiency ratios for each of the three patient classification models. Prior to the RAM for FY 89, facility efficiency ratios were compared to system-wide averages. If productivity was above average, the facility received additional funding and was, therefore, a winner. If below average, the facility lost money, i.e., it was a loser. In concept, the RAM operated the same in FY 89 except that all facilities were placed into peer groups (VAMCs with similar size, scope of services, case-mix complexity, educational mission, and cost structures). Comparisons of efficiency were made within each group rather than with the system as a whole.

The VA RAM represents the state-of-the-art in the field of medical care funding mechanisms. The simplified description presented above does not hint at its actual sophistication and complexity. Winner and loser are accurate terms from a budget standpoint but these simple labels can obscure a number of important factors which should be considered in assessing a facility's performance under the RAM. For example, a facility can be more efficient than average in one or two of the three models but the net effect of all three can be negative. A facility may also be classified as a loser but less so than in the previous year because of improvements in efficiency. Finally, there are many elements which determine efficiency levels as measured in the RAM and some of these may be beyond the control of facility management. Partially for this reason, RAM losses and gains are capped so that the budget change for each facility is modest in relation to its overall allocation. RAM losers normally experience an overall funding increase because the RAM adjustment is minor compared to additional amounts given for salary increases, special pay, inflation, and other budget items.

Question: 2. I am told that you have a task force studying the FY '89 budget and that that task force has indicated a shortfall in that budget in excess of a billion dollars. I am also told that the task force presented to you some 86 options as to how to possibly meet that shortfall. Is my information correct and, if so, have you decided to accept or implement any of these options?

Answer: Yes, your information is correct. The following task force options have been accepted by the Chief Medical Director and are in the process of being implemented:

(1) Establish and issue fiscal policies for the FY 1989 Medical Care Appropriation which will provide the field with conceptual guidance on how to respond to the budgetary challenges facing the Department. These policies will provide a direction relative to the ensuing immediate action plan elements to be carried out by the field beginning on October 1, 1988.

CONGRESSMAN SOLOMON (con't.)

(2) Adopt a workload management control policy based on the objectives of achieving geographic equity of access to care, by controlling the quantity of discretionary workload to be undertaken by each VAMC.

(3) Protect equipment accounts and nonrecurring maintenance (NRM) accounts by allocating those funds as budgeted, in view of documented evidence that the required reallocations out of these accounts in FY 1988 created a significant threat to quality of care.

(4) Decentralize to VAMC's the management of non-VA workload accounts and the unearmarking of related dollars.

(5) Appropriate major revisions of resource allocation system will be developed, based on following objectives:

- o Incorporation of quality of care as explicit factor in allocation process.
- o Accomplishment of workload management and geographic equity of access to care.
- o Elimination of open-ended incentive for workload expansion.
- o Process and timetable for development of these proposed revisions to be developed.

Question: 3. How many VA hospital beds nationwide are closed due to the nurse shortage, and how many beds are closed due to a lack of funding?

Answer: As of July 31, 1988, there were 2,763 beds closed VA-wide due to nursing staff recruitment problems. The VA does not maintain a record system regarding beds closed for the reason of "lack of funding".

Question: 4. On page 9 of your statement, you say "...we at some point will be in a position of limited opportunity to make further internal expansions of productivity." Isn't it true that you have been beyond this point for some period of time?

Answer: In recent years, the Department of Medicine and Surgery has achieved productivity gains, despite budgetary constraints. However, in 1989 the Department will be at a critical juncture where the opportunity for additional productivity expansions is severely limited.

Question: 5. Is it correct that many hospitals have spent all or part of their equipment funds, and maintenance and repair funds to cover operating expenses for the remainder of Fiscal Year 1988? How much money was involved?

Answer: Yes, many hospitals have spent their equipment funds and maintenance and repair funds to cover operating expenses for the remainder of FY 1988. Approximately $66,364,419 is involved. Breakout is provided below:

Equipment - (Net of Replacement Equipment account which was under plan by $40,579,000 and additional Equipment account which was over plan by $21,138,000 in FY 1988.)	$19,441,000
NRM	$41,279,000
Other	5,644,000
TOTAL	$66,364,000

CONGRESSMAN SOLOMON

Question: 6. What are the consequences in terms of 1989 of VA hospitals having used up their non-recurring money to pay salaries in 1988?

Answer: The consequences are that a significant amount of those 1988 non-recurring monies that were used to pay salaries in 1988 will be added to the 1989 non-recurring money needs.

Question: 7. The Department of Veterans' Benefits has a program called "Outreach". The program is designed to make veterans aware of benefits and services available to them. We have been told that when a VA Hospital Director does this same thing in terms of services available at their facility that this is frowned upon and is called "marketing". Have the VA hospitals across the country been told that they are not to engage in marketing their services?

Answer: The Department of Medicine and Surgery does have an active consumer affairs program to inform veterans and the community about VA's health care programs. Information programs are encouraged and supported by the department. Medical Center Directors have been told to inform veterans about health care services and benefits that are available to them. Directors have not been told that they should not engage in marketing their services.

Question: 8. Is it true that clinic appointments have been stretched out far behind the normal number of weeks or months that are medically indicated?

Answer: All clinic appointments are made based upon what is medically indicated by the physician. If the patient requires emergent care an early appointment is scheduled. Other appointments are made based upon the next available appointment in the specific outpatient clinic. The next appointment time can range from a few days to six months. However if the condition of the patient deteriorates the scheduled appointment can be changed to meet the patient's medical condition. At all times the veteran's medical condition is considered before setting the appointment time.

Question: 9. On page 11 of your statement, you state that the nursing shortage in the private sector is 11 percent while VA's nursing shortage is approximately 4.6 percent. Do these comparative percentages hold true in large cities of this nation such as Los Angeles, New York, Boston and Atlanta?

Answer: As discussed during the hearing, the VA-wide vacancy rate is approximately 4.6%; however, we experience considerable variance in large metropolitan areas as shown below for selected VA Medical Centers.

Boston	16.5%	Nashville	0.9%
Bronx	2.4%	Lexington	3.4%
Brooklyn	6.3%	Miami	2.3%
Montrose	24.2%	Cleveland	-1.8%*
New York	7.6%	Allen Park	6.5%
West Haven	24.9%	Indianapolis	9.5%
East Orange	10.2%	Milwaukee	3.9%
Philadelphia	4.5%	Chicago (WS)	2.3%
Pittsburgh (UD)	10.1%	Minneapolis	2.6%
Baltimore	17.7%	St. Louis	6.9%
Fort Howard	33.4%	Iowa City	10.9%
Washington, DC	14.4%	Denver	7.9%
Durham	14.9%	West Los Angeles	11.0%
Atlanta	3.8%	San Francisco	-10.7%*
Richmond	6.5%	Seattle	12.7%
Dallas	-0.5%*	Albuquerque	11.5%

* A negative number indicates that nursing staffing is above their assigned ceiling.

CONGRESSMAN SOLOMON (con't.)

Question: 10. On page 3 of your statement, you included one-day dialysis treatments in determining your total number of outpatient visits. How was this type of treatment previously counted? How is the allocation of money impacted?

Answer: Prior to 1987, one-day dialysis treatments of ambulatory patients were reported as one-day hospital admissions. One-day dialysis treatments were reclassified as an outpatient procedure for administrative purposes and to bring VA record keeping more in-line with academic and private hospitals. This reclassification does not affect the range of services or the quality of care provided VA dialysis patients.

There is no change in total budgetary resources, or the allocation of resources, as a result of this reclassification. The chart on page three of my statement reflects the reclassification of one-day dialysis from inpatient to outpatient in 1987 and were adjusted for consistency purposes.

Question: 11. Is it proper to determine occupancy rates in VA hospitals by including beds that are not really in use and not staffed?

Answer: Currently, VA hospital occupancy rates are calculated using average operating beds, which include some beds that are not staffed. A new definition and formula for computing occupancy rates, in which only staffed beds will be used, is currently being developed. It is anticipated that this new method of computing occupancy rates will come into use sometime during Fiscal Year 1989. Thus, it is not proper in our judgment to compute occupancy rates including unstaffed beds.

Question: 12. It has been stated that VA has more nursing FTEE now than it had a year ago. Does this take into account the many outpatient clinics that have been opened and staffed with nurses and that actually there is a lesser number of nurses in the VA hospital system than a year ago.

Answer:

RNs	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.
FY 1987				
NON-CUMULATIVE	33,710	33,467	33,594	34,073
CUMULATIVE	33,710	33,590	33,592	33,713
FY 1988				
NON-CUMULATIVE	34,217	34,046	33,721	33,542*
CUMULATIVE	34,217	34,132	33,996	–
VARIANCE				
NON-CUMULATIVE	(507)	(579)	(127)	531
CUMULATIVE	(507)	(542)	(404)	

*PP18 ENDING 9/10/88

Yes, as the above chart indicates, it is true that there are more nursing FTEE this year than a year ago. The increase can be attributed in part to the activation of mostly outpatient areas such as Outpatient Improvements, Satellite OPC's, Replacement Modernizations, Nursing Homes, and New Clinical Improvements.

HON. CHRISTOPHER H. SMITH TO VETERANS' ADMINISTRATION

CONGRESSMAN SMITH

Question: 1. Do you believe the funds provided by the FY 1988 supplemental appropriation (31.7 million) will enable VA Medical Directors to operate their facilities without being forced to continue shifting funds from one account to another?

Answer: The 1988 Supplemental provided funds related to PL 100-322 which increased certain authorities for outpatient care as well as other programs. When the Supplemental was received funds were restored to the accounts from which they were taken to implement the mandatory requirements of P.L. 100-322 in FY 1988.

Question: 2. In later testimony, Dr. Paul Schafer, Executive Director of the National Association of VA Physicians, claims that in many VA facilities, physicians must treat patients with substandard equipment (obsolete kidney dialysis machines, broken aortic balloon pumps, etc.). Since money is being shifted from accounts that would be used to fix and update this equipment, how does the VA plan to maintain adequate equipment for patient care?

Answer: Funds necessary to maintain adequate technology in order to maintain the standard and quality of care will be requested. Since shifts from non-recurring capital accounts are clearly a short-term measure, these diversions will not be permitted as a matter of policy in FY 1989. Budgetary shortfalls, if any, will then equate directly to reduced workloads.

Question: 3. You state in your testimony that the VA has increased both in and outpatient care with no real increase in cost to taxpayers while private sector hospitals have experienced a 20% increase in cost productivity. Can you give me examples of how the VA increases productivity as related to patient care? You also mention in your testimony that at some point, the VA will be in the position to make further expansions of productivity. Will you elaborate on this?

Answer: 3a. Examples of increased productivity resulting in cost savings are as follows:

A VAMC revised purchasing procedures and improved inventory control for Pharmacy Services resulting in a large savings.

Through the utilization of its own employees in the Biomedical Engineering Service to provide service on VA equipment instead of using maintenance contracts, a VAMC saved the cost of maintenance contracts.

On a trial basis, at one facility, the services of Registered Nurses in the Surgical Intensive Care Unit and the Medical Intensive Care Unit have been combined. This consolidation of staff requires five less RNs.

3b. The VA will be able to make further expansions of productivity by doing the following:

The Department of Medicine and Surgery is required to achieve a 20 percent productivity increase between 1986 and 1992. Seventeen percent of this productivity increase is measured in weighted work units (i.e., WWUs which are the health care resource requirements for different types of patients) relative to the number of FTEE who provide direct patient care. The remainder of the 20 percent increase is by ADP applications in DHCP. This increase in productivity is more significant when the workload increases are compared with the staffing shortages in direct patient care areas.

QUESTIONS OF THE HONORABLE GERALD B. H. SOLOMON
TO THE HONORABLE THOMAS K. TURNAGE
VETERANS ADMINISTRATION
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING OF SEPTEMBER 7, 1988

QUESTION 1: Whatever happened to the $26 million supplemental that we were told one day was forthcoming to Capitol Hill, but which never arrived? This is separate and apart from the $31 million supplemental mentioned by the Administrator on the first page of his testimony.

ANSWER: The $31 million supplemental approved covered all of the requirements of the $26 million supplemental and included an additional $5.8 million for Saturday Premium pay. The $26 million supplemental never arrived due to internal negotiations over what accounts should be used as appropriate funding offsets. These internal negotiations were overtaken by Congressional passage of the $31 million.

QUESTION 2: Have you recommended a budget supplement for FY'89 to OMB for medical care? If so, how much money is being requested?

ANSWER: We have requested supplemental funding. Specifics regarding funding amounts are embargoed pending OMB review.

QUESTION 3: The Post article on August 31st quoted you as saying in reference to having required 90,000 beds in service, that the VA has never had since you arrived at the VA. Would you please elaborate on the 90,000 bed requirement?

ANSWER: VA policy is to operate and maintain the number of hospital, nursing home and domiciliary beds sufficient to meet the needs of veterans who apply for such care. In addition, we maintain an additional number of beds as necessary to meet the contingency bed requirements of P.L. 97-174.

The law sets the floor of hospital and nursing beds at 90,000. When this floor was established several years ago, consensus held that this was an appropriate minimum operational level. Since then, medical practice patterns, including those of VA physicians, have evolved, reducing average length-of-stay, and making more clinically appropriate the several alternatives to bed care which are, or can be, made available. Thus, as we testified before your Committee, we are able to continue increasing the numbers of patients treated with the VA system, while relying on fewer beds.

The bed occupancy rate for hospital care in VA medical centers for all of FY 1987 was 71%, approximately 8% more than the same measure for community hospitals in calendar year 1987. Our bed planning methodology assumes occupancy rates of 85% for planning purposes.

In the final analysis, the appropriate bed operating levels are determined primarily by the expressed demand for care, patient acuity and severity of illness, and availability of staff to provide care which meets VA standards. As these variables change over time, so will the actual bed complement. The VA needs flexibility of bed management in order to be both efficient and effective as a provider of care for an aging, complex, patient population.

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QUESTION 4: Department officials in DM&S have been quoted as having said that if your 1989 money comes to you as currently indicated by the Appropriations Act, and if there is no supplemental forthcoming, you will be treating only Category A veterans. Firstly, do you anticipate such a supplemental and, if so, how much, and if you do not receive one, what will be the impact on 1989 at VA hospitals?

ANSWER: We anticipate inclusion of a supplemental request for FY'89 in the President's budget to be submitted for FY'90 but the amount of the supplemental is not known at this time.

We have developed plans for coping with the resource shortages which would result if there is no supplemental for FY'89. These plans are intended to ensure that impacts on VA hospitals do not impinge on our ability to deliver high quality care to veterans whose care is mandated by statute. Moreover, we are required to satisfy appropriation law requirements regarding personnel services expenditures and we must implement certain, mandatory provisions of P.L. 100-322 in the areas of AIDS prevention, increased state home per diems, Saturday premium pay and tuition reimbursement for nurses, among others.

Having ensured that we will accomplish the essential elements of our mission as outlined above, we will reduce expenditures to within the amounts appropriated principally by reducing our discretionary patient workload. The impact of this policy will vary throughout the system because the proportion of mandatory to discretionary workload spans a considerable range. To better achieve equity of access to care, we will shift resources among seven DM&S regions so that there is a balance based on the amount of affordable discretionary care available. Each region will then develop a workload plan which will project the number of mandated and discretionary patients to be treated. As the year progresses, funds will be shifted, as necessary, from facilities treating more than their share of discretionary patients to facilities which, because of the volume of mandatory patients and other such factors, find themselves short of funds required to treat the number of discretionary patients in the original, regional plan.

While reducing discretionary patients is the keystone of our plan, we intend to reduce costs in several other ways as well, for example by decentralizing to VAMCs the management of certain non-VA workload accounts, restricting prescriptions written by fee-basis physicians to drugs in the VA formulary, and restricting organ transplant services to care-mandated veterans in VA facilities or facilities with which we have sharing agreements.

DAV RESPONSES TO QUESTIONS
OF
CONGRESSMAN GERALD B. H. SOLOMON
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING OF SEPTEMBER 7, 1988

Question 1: I received a letter from DAV Commander Billy Kirby on August 2, 1988, alerting me to the funding crisis facing the VA. Can you describe how you acquired this information...written survey, telephone contact, etc.?

Answer: The information contained in and appended to Commander Kirby's August 2, 1988 letter was derived from a variety of sources. The majority of the information was furnished by DAV National Service Officers in response to a written request by National Adjutant Charles E. Joeckel, Jr., dated June 30, 1988. That request solicited information concerning instances where VA medical facilities had terminated or restricted services to veterans, as well as delays in processing benefit determinations. Additionally, individual veterans periodically contact us by letter or telephone with specific information concerning their experiences when seeking treatment at VA medical facilities. This information, in broad terms, was also contained in Commander Kirby's letter. Finally, we obtained a draft copy of, Chief Medical Director's Task Force Report on Fiscal Year 1989 Budget and included information from that document in our August 2, 1988 correspondence.

Question 2: Have you provided VA Administrator Turnage or Dr. Gronvall this information?

Answer: Yes.

Question 3: Does your survey indicate that Category A veterans are being denied care in VA Medical Centers?

Answer: Yes. At the September 7, 1988 hearing, the DAV provided Chairman Montgomery with a list containing veterans' names and documented circumstances of care being denied or, in our view, inappropriate care being provided by VA.

PVA's RESPONSE TO QUESTION BY
THE HONORABLE CHRISTOPHER N. SMITH
CONCERNING SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE HEARING
SEPTEMBER 7, 1988

Question:

You site many examples in your testimony of recent restrictions in the delivery of care at VA facilities. Has your organization also sensed an increase in the dissatisfaction among individual veterans in regard to their treatment by the VA?

Answer:

As indicated in our testimony, PVA's informal survey indicated that serious budget shortfalls in the VA has resulted in, for a variety of different causes, veterans being denied treatment and veterans enduring unacceptable delays in their treatment. While our survey made no direct measure of dissatisfaction among individual veterans, we respectfully submit that the recent restrictions in the delivery of care at VA facilities have indeed resulted in a higher incidence of dissatisfaction among veteran consumers.

PVA has provided the Subcommittee with a multitude of concrete examples of the increase in restricted access to VA care and treatment. PVA members know from personal experience that the veteran is dissatisfied when his activity is restricted to bed rest because his pressure sore cannot be scheduled for operation for three months or more; when the VA pharmacy "runs out" of her prescription medication forcing the veteran to purchase it herself or go without; when a veteran is homebound because the VA is unable to repair or replace his wheelchair; or when a hospitalized veteran must put his needs on hold for awhile because the nursing staff is just too short-staffed and busy to tend to him/her.

PVA believes that the VA health-care system is in deep trouble. Years of budget shortfalls have resulted in the system's inability to maintain bed levels, staffing levels, and timeliness in the provision of essential, medical services.

While the informal survey did not address satisfaction levels, an increasing number of calls from the field, from our service officers, our members, and other veterans indicates that there is a growing feeling of dissatisfaction, frustration and concern among veteran consumers of VA health care.

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